HIV Transmission during sex between men: who's failing, what's failing?

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Good afternoon.

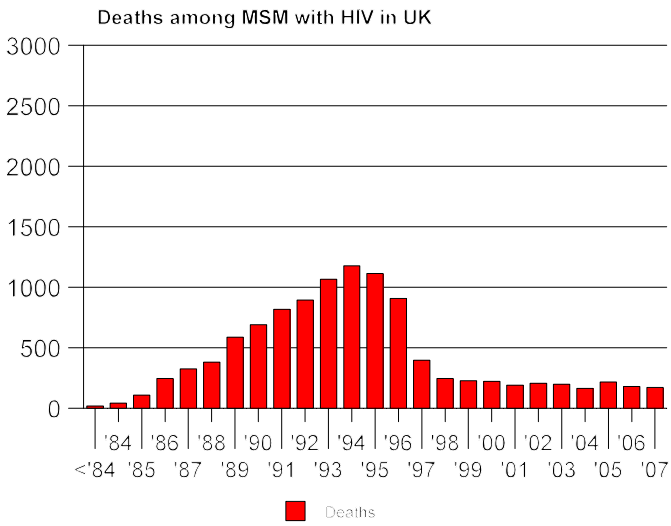


Figure 1 graph shows the number of men who have died in the UK each year with (not necessarily from) homosexually acquired HIV.[1] The year of the largest number of deaths among gay and bisexual men with HIV in the UK was 1994, when 1,177 men were recorded to have died. You can see that the rising tide of deaths was severely curtailed by the introduction of combination therapy in the mid-1990s, since which time the number of deaths each year has stayed between one and two hundred. In total around 11,000 gay and bisexual men have died with HIV in the UK to date.

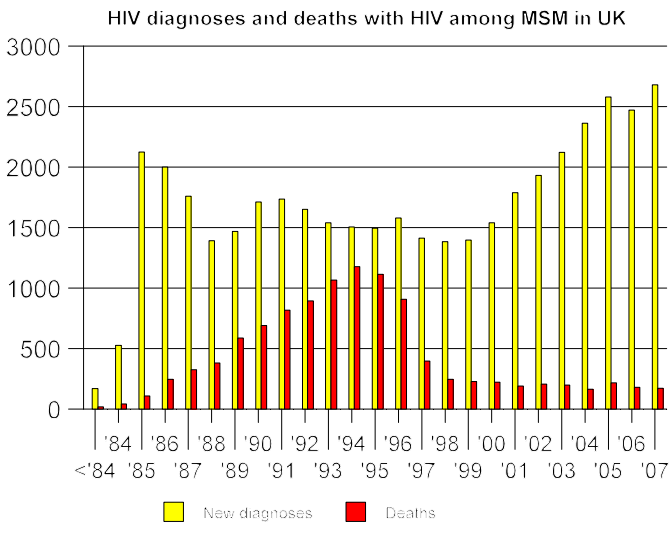
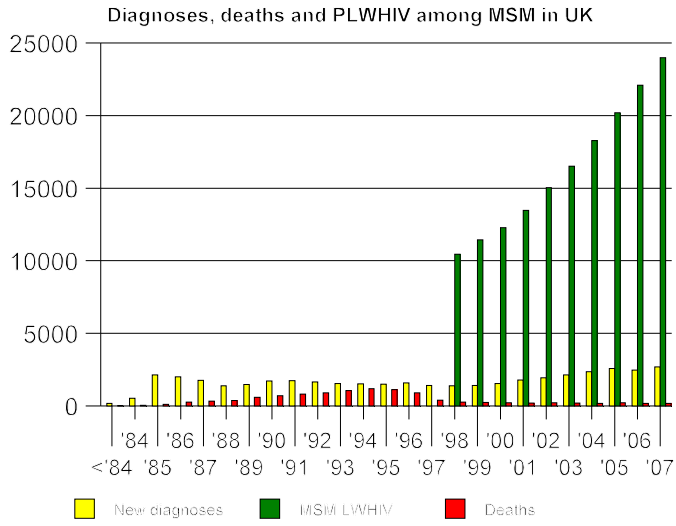


Figure 2 adds on the number of gay and bisexual men newly diagnosed with HIV infection each year (to the left of the number of deaths). The HIV antibody test was introduced at the end of 1984 and became widely available during 1985 when a 'back-log' of infections were diagnosed. The number of diagnoses dropped to low points in 1988 (with 1,391 diagnoses) and in 1998 (with 1,384 diagnoses) before rising almost every year since. It is important to note that these are diagnosis events and not

infection events which will have been some years earlier.[2]

What I want you to note is that in no year has the number of deaths been greater than the number of new diagnoses. In fact, the smallest number of new diagnoses (in 1988 and 1998) is greater than the largest number of deaths in 1994. What this means is that the number of gay and bisexual men living with HIV has only ever got bigger. Because we are more successful at preventing people with HIV from dying than we are at preventing people without HIV from acquiring it, the number of people living with HIV continually grows.

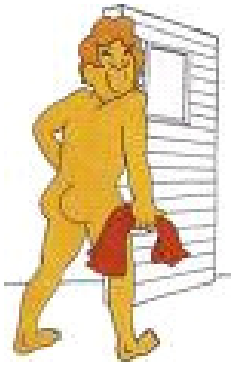
Figure 3 adds the number of men living with HIV each year as counted in the HPA's SOPHID survey (in between the number of new diagnoses that year on the left and the number of deaths on the right). Notice that the top of the left hand scale has increased from 3,000 to 25,000 men. You can see that there are now almost 25,000 gay and bisexual men living with HIV in the UK, more than twice the number than have ever died with it. How do we react to these data?



The key note of HIV has always been **blame**. The key mechanism for responding to HIV has always been **othering** - the process of making people with HIV different from people without HIV, and the process of making HIV someone else's problem. Both blame and othering come fully to the fore when we consider HIV infections during sex between men. We seek someone to blame, and we make it someone else's problem.

Collectively the UK is failing to reign in HIV.[3] Put simply, this is because the forces toward risk behaviours are simply much greater than the forces towards precautionary behaviours. I will argue that the forces for risk behaviour are large and diffuse. On the other hand the forces for precautionary behaviour are meagre and narrowly focussed. I'm going to briefly review the forces for sexual HIV risk behaviours and the forces for HIV precautionary behaviours, in order to make a more realistic appraisal of the situation we are in, to put our efforts into better perspective, and to question the function of the claim that HIV prevention is failing.

So, what are the large and widespread forces for sexual HIV risk behaviours? The first thing I want to acknowledge is the sheer **power of the pleasure** of a desired for homosexual encounter, either with a stranger or a lover. I want to recognise the strength of intercourse with the right partner, and the differences in sexual flow and sensation of intercourse with and without a condom. I am, quite frankly, sick of people saying they can't understand why anyone would have sex with a risk of HIV transmission. Just over a year ago we were treated to the TV spectacle of Stephen Fry not only mislead the nation about the epidemiology of HIV in the UK, but also denounce as stupid gay men who take sexual pleasure that carries a risk of HIV.[4] For years one of Britain's best known celibate gay men, Fry was demonstrably stupid in not recognising that some of us prefer a good fucking to a nice cup of tea. The vast majority of risk is driven by desire. Sexual desire remains a mystery to those not experiencing it. What is one man's revulsion is another man's thrill. If you do not understand sexual risk, it is probably because you don't appreciate sexual desire.



All sexual risk behaviours are a subset of sexual behaviours and all other things being equal an increase in sex is accompanied by an increase in risky sex. The gay **sexual market place** has been a boom business in the last 10 years and is a major force towards risk. The gay scene is no longer a few pubs, clubs, cottages and cruising grounds but a large business sector supplying services for sexual contact and locations to have sex. The Internet and saunas

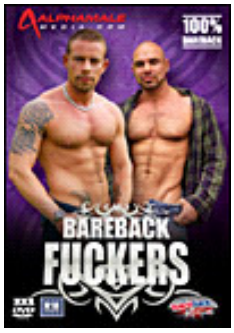
are two obvious examples of the increasing reach of the sexual market place. The internet has also facilitated the boom in the porn industry over the last decade, which has both supplied opportunities for risk taking by those making the films, and a desensitisation or normalisation of risk practices among those consuming them.

We know that sexual risk is fostered by negative moods[5] and I would maintain that there is **widespread emotional isolation and low mood** among gay and bisexual men in the UK. The most commonly hoped for life change among gay men is for a close emotional relationship with another man, not something supplied by the sexual market place and certainly not something to be got from being in or consuming porn. I make no apology for pointing out, again, the widespread and casual denigration of homosexuality that pervades our culture. From the spiritual leaders of millions[6] to popular broadcasters[7] to everyday school and workplace practices, attacking us or making a joke of us, remains routine. Yes, we have made massive advances in equality in the last decade. Yes, protective legislation is making a difference. But these changes will take further decades before their effects are fully felt. In short, it would be remarkable if sexual minorities did not, as a group, suffer more mental health problems across the spectrum than the sexual majority.[8]

A lot of suppressed mood requires a lot of mood enhancement. Gay and bisexual men are adept at **self-medication with alcohol and drugs**. There is an ever expanding market in the supply of drugs on the gay scene with new letters being added frequently. The sexual market place is commercially dependent on them and taking them is normative. Anxiety at being in the sexual market place is a major driver of alcohol and drug consumption.[9] Substance use is what might be called a second tier HIV risk behaviour. You cannot get or pass on HIV by drinking, eating or smoking drugs, no matter how much you consume. However, substance use can undermine prevention needs. Substances disinhibit and our culture excuses risk taking under the influence, so whether causal or not, drink and drugs often precede risk. At the sharp end, people not in control of the substance use are not in control of their risk behaviours.

There is now a widespread **expectation that when sex takes place, it will involve anal intercourse.** Always use a condom assumes you will always fuck. Prevention based around the notion that everything is fine as long as you use a condom reinforces a social norm that anal intercourse is a yard stick for real sex. Safer sex has come to mean fucking with a condom rather than doing something other than fucking. The expectation of fucking is a force toward HIV risk because fucking, even with a condom, is an HIV risk.

The hard-hitting condom every time messages of the 1990s that are now being viewed nostalgically have left us with a complex heritage of cultural and counter-cultural norms.



Barebacking has become normalised as a transgressive behaviour for gay men. Unprotected intercourse used to be simply am HIV risk behaviour. When universal condom use became the norm that all good gay men should aspire too, some bad gay men saw barebacking as a two fingered salute to the health fascists who banged on about condoms all the time. Gay sub-culture has long legitimised the eroticisation of unacceptable thoughts. Having been told the lie that our normal desires were abnormal, some of us sought to explore the power of forbidden thoughts. Barebacking porn is the most visible manifestation of this understanding. Risk has been commodified and fetishised.

A further cultural norm providing a force toward risk among gay men is the **dissipation of responsibility for precautionary behaviours**. The idea that "I leave it up to him to use condoms" is not uncommon among HIV positive men having casual sex, especially in anonymous settings like saunas and backrooms.[10] Our individualised, client-focused, look-out-for-No.1 approach is wholly supported by the sexual market place and means that if one partner fails to take precautions the other is also justified in not doing so. Safer sex being everyone's responsibility has come to mean risky sex is no one's responsibility. Just as health agencies are failing to take care of gay men, gay men are failing to take care of each other. The idea that you would sacrifice something yourself in order to protect or care for someone else seems, at the

moment, to be deeply alien to gay culture and HIV precautions.

Finally, some of the most powerful forces towards risk behaviours come through the **optimistic biases and twisted thinking** that all of us engage in when faced with a potentially dangerous desire. We tell ourselves that the good outcome is more likely than it is, that the risks are less large than they are, in order to do something we want. This is not peculiar to gay men and is not limited to sex.

So, I maintain, the forces toward sexual HIV risk are large and widespread. On the other side of the scales, most of the forces toward precautionary behaviours are meagre and narrowly focussed.

Firstly though, I do not believe that the most obvious force for prevention, the **desire to avoid HIV infection among the uninfected**, is weak. For well over a decade now we have heard that gay men, particularly young gay men, are not fearful enough of HIV, that they did not see their friends die in the 1980s, that they think HIV can be solved with a few pills. Regard for HIV in a population, be it debilitating fear or inconsequential dismissal, is always a profile, a range of opinions, a diverse set of perspectives. Gay men are varied. Having said that, the evidence we have points to these assertions being, on the whole, nonsense. They are part of the easy blame culture that surrounds HIV. The majority of uninfected men would decline *any* sexual contact with a man they knew had HIV. This is particularly the case for younger men. The majority of uninfected men think a man with diagnosed HIV who passes his infection to a sexual partner he has not disclosed to, should be imprisoned. Men think this predominantly because they conceive of HIV as a death sentence, a catastrophic harm to health. This is particularly the case among younger men. Very few uninfected men who had a casual unprotected fuck last night would have done so had they known their partner was HIV positive. Among uninfected men fear of HIV, and of men with HIV, is if anything, excessive; an excess founded in ignorance. Understanding on the other hand seems in short supply and seems to be decline.

I fear that our gay community response to HIV is in danger of being reduced to NHS services, and that NHS services have been swamped by the values of politics and business.

It is undoubtedly the case that the amount of **money available for HIV education has declined** as the number of people living with HIV has increased.[11] As the amount of money available has contracted, competition for these meagre resources has become a major preoccupation of agencies. Leadership has been replaced by salesmanship and competition has replaced collaboration.

Not only is the amount of resources available contracting but what we do with seems to be getting narrower. There is a danger that the gay community response to HIV is being replaced, not supplemented by, the behavioural-treatment of faulty individuals, what I will call the **high risk strategy**, after epidemiologist Geoffrey Rose[12] but which could also be called the Jim'll Fix It approach to HIV prevention.[13] The forces for prevention are increasingly focussed on identifying and rectifying men having unsafe sex. We increasingly invest in the strategy of trying to deliver behaviour change interventions to high risk men, while leaving the social and political environment unchanged. This strategy alone is inadequate for a number of reasons.

Firstly, **HIV risk is widespread.** It is not the case that a small group of hard core risk takers account for the new infections. In the coming year about half of all homosexually active men will fuck without a condom; the majority of those will do so without knowing for sure they and their partner share the same HIV status. At most 1% of the uninfected men will acquire HIV. Which men who take a risk will sero-convert is unknown. The transmissions that occur over the next year will be the unlucky ones in a large population each taking a few risks.

Secondly, the high risk strategy is inadequate because the **prevention budgets are too low for the unit costs of effective interventions.** I say this with caution because although we do have interventions that can reduce HIV risk behaviours in a client group, it is difficult to establish their cost-effectiveness because community groups have become service providers which are commercially sensitive and have therefore become secret and competitive.[14] We cannot have a transparent and evidence informed debate about the performance of programmes because the language and values of business have so overwhelmed our public services and community responses. In the business model, interventions are treated as products, potentially profit making products that need

guarding. They are always talked up by the agencies trying to sell them, creating an on-going and unrealistic expectation of what they should achieve, and ensuring that failure is not only likely but also hoped for by competitors.

Thirdly, the high risk strategy **is focussed on stamping out unsafe sex rather than preventing it**. So, for example, it has nothing to say about educating men at the start of their sexual career, but waits until they inevitably start having unsafe sex and then tries to fix them. HIV education should not be about stopping men having unsafe sex but about preventing future risk behaviours in a population. Demands that all interventions change the risk behaviours of individuals will ensure we have few programmes that make risk behaviours less likely in the population.

Fourth, the high risk strategy is only concerned with the largest profit for the smallest payout with **little or no regard for equity of need**. The interventions that are prioritised are those which meet the public health imperative of maximum reduction in new infections, rather than most equitable control over HIV. A small sub-group with high HIV incidence, Black gay men for example, is of little interest to the high risk strategy if they are difficult or expensive to deliver interventions to. A sub-group with extensive unmet need but relatively low incidence, such as bisexual men, are left to their own devices.

Let me clear. I am not against one-to-one counselling, safer sex mentoring, or small group work for men with entrenched and persistent problems with safer sex. Far from it. These interventions need better funding, better training and better targeting. **Evidence from the evaluation literature** suggests they are more likely to be effective if they are well resourced, are based on theoretical models of change, are preceded by needs assessments, consist of multiple components and focus on both practical information and relevant skills.[15] But for the reasons outlined, we will not service our way out of this epidemic. Such services are treading water in terms of population level change.

So, I maintain, our meagre prevention resources are too narrowly focussed on men having sex rather than on the political, social and commercial environments in which it takes place. Other potential forces for prevention do not fall in our favour.

The public health tool of alerting the public through epidemiological data can be a force for prevention. **Public health press releases** are a form of public health warning; they are written to make people think it might happen to them and so increase the chances they will take precautions. Press releases also influence the concern and responses of funders, services and communities. However, this force has rarely been expended in the interests of gay men. Instead it has been brought to bear almost wholly in favour of young straight people. For ten years in the UK press releases have been written to give the impression that straight Africans moving to the UK with HIV are actually young straight Britons acquiring HIV. The depth of the consequent public and professional misunderstanding about the epidemic is profound.

Even the educators are ignorant. For example, the British Red Cross produces a teacher's pack about HIV for schools in the UK. The ten-minute briefing currently on their website[16] is "designed to equip educators with accurate and relevant information in order to discuss HIV and AIDS with young people." The pack informs us that "until recently, the virus mainly spread through men having sex with men. However, most new HIV infections in the UK now happen through heterosexual sex between young people." This simply is not true.[17] Who's failure is this? Why would anyone think this were the case? And who does it show concern for?

The HPA is not responsible for the racism and heterosexism of the media but it has been complicit with them. Aware that the country will be disinterested in HIV if we know it's mainly just a gay thing, data has constantly been presented to make it look like it is not.

We have, as a community, been woefully let down by the **government social surveying** that occurs across a wide range of topic areas. Failure to include a sexual identity question in, for example, the *British Crime Survey*,[18] or the Schools Health Education Unit's *Health Related Behaviour Questionnaire*,[19] has meant that evidence based planning is planning without sexual minorities. When challenged the designers of such surveys suggest they 'can't ask everything', or they point to the very real resistance they get from homophobic stakeholders. These are reasonable

excuses only from researchers unwilling to fight for the causes their research is ostensibly designed to forward. In either case, the outcome is a lack of data about the groups possibly most likely to be in need. The homophobia that causes the problems is the same homophobia that ensures the problems are hidden. And so we reach the fundamental problem of evidence based planning: that the available evidence is not impartial. Evidence is generated about what society is concerned about, and is then used to justify what gets dealt with.[20]

The **concern of public health agencies and the public** is not with gay men. That potentially large force for prevention - the sustained concern of the caring professions - is simply not there for us. Fleeting concern, maybe. Lip service concern, certainly. But not sustained, problem solving, invested concern. In the AIDS sector, gay men's HIV prevention is ghettoized and marginalized. Our sex lives an embarrassment to fund-raising, our continuing infections a source of irritation and bewilderment. We have never been the subject of a world AIDS day, internationally or in Britain. We are constantly referred to as the history of AIDS rather than shouldering its current impact. We are constantly downgraded in concern and blamed for our own inadequacies.

Instead we are bunged a small amount of money and told to get on with it. When those resources are inadequate we are denounced as failing. In order to take control of those meager resources we denounce each other as failing, thereby justifying the diverting of funds to other health problems. When we fail to achieve the impossible we are an easy scapegoat for the nation's short comings.

If as a nation we are failing to curb new infections, one of the reasons we are failing is because we place responsibility for success solely on the shoulders of a small number of specialist HIV education charities. The claim that HIV prevention is failing is a victim-blaming tactic that becomes a self-fulfilling prophecy. Anyone who says HIV prevention is failing wants it to, usually so they can either take the reins or take the money.

So instead I maintain that HIV prevention is simply inadequate. Our schools and universities are inadequate; the public and professional communication of HIV surveillance data is inadequate; Chris Moyles is inadequate; the media reporting of HIV is inadequate; the funds available

for HIV prevention are inadequate; NHS commissioning for HIV is inadequate; the *Jim'll Fix It* approach to HIV prevention is inadequate; the Pope is inadequate; the concern of the caring professions is inadequate; leadership on the domestic HIV epidemic from our politicians is inadequate; Stephen Fry, dare I say it, is inadequate.

So what needs to change? For most of us most of the time, taking precautionary measures against HIV during sex is fairly easy. Stopping all men from taking any risks is not only difficult, it is not possible. Anyone who claims they have the solution to the HIV epidemic is either a liar or a fool. Anyone who berates HIV agencies for not implementing their solution is engaging in little more than self-indulgent posturing.

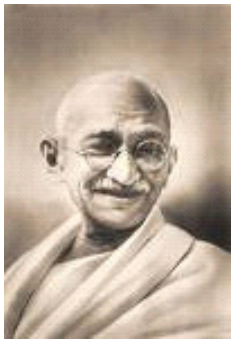
So I have no solution for stopping the epidemic. Instead I would like to offer a few pointers for keeping focussed on what matters, for continuing to carry out work which is meaningful to us and useful to the men we work with and for thinking about the direction we need to move in if we are to make a difference rather than simply blaming and othering,

Two key mechanisms of homosexual oppression have for a long time been silencing and homogenising. Silencing means we are simply left out of consideration. So I thank each and every one of you who, in towns and cities across the country, have raised your voices in the interests of gay and bisexual men. It still takes courage and perseverance to do this. The worst thing we can do is fall silent. I want to warn against the very real threat of our community based organisations being appropriated by the NHS and by the state. Organisations afraid to bite the hands that feed them make poor advocates for their communities.

The second major mechanism of homosexual oppression, homogenising, is the assumption or portrayal of sameness. As all of you will know, gay and bisexual men are very varied. We come in all shapes and sizes, from all ethnicities; we range from the youngest to the oldest, the richest to the poorest. We are varied in our style, our tastes, and in our behaviours. We have different interests, different desires, different concerns and different values. We need to resist one-size-fits-all responses to HIV.

Historically we have lurched from one partial solution to another, investing in singular responses that can never meet the needs of the diverse gay population. So we need to work on combination prevention

that exploits all the mechanisms by which risk can be reduced.



Mahatma Ghandi suggested that "**We need to be the change we wish to see in the world**" is usually attributed to. If we are manipulative, combatitive, misleading, bullying and self-interested in our dealings with our colleagues and our clients we encourage gay men to be these things with each other. These approaches are not sustainable, either individually or collectively. And we need a sustainable prevention. That means being candid, co-operative, honest and respectful. Above all it means asking ourselves, "On whose behalf are we working? In whose interests do we act?".

The philosopher David Hulme is reputed to have proposed that "**Truth springs from argument among friends**".[21] So we do need to be open to questions. We do need to have heated debates. In particular I think we need to debate the properties of the gay population and how they might be changed.

But when you feel like claiming HIV prevention is failing, be specific. What is failing? Who is failing? If we cannot be specific about our failures we cannot be specific about our successes.

I propose that the meaning of success in HIV health promotion is not no new infections. It is that the world is better for our action compared to if we had not acted. The meaning of better does not belong to us but to the men on whose behalf we work. Those of us working in community education are not failing because we are unable to counter the forces railed against us. We are failing if we do not try.

Finally, I think we need to appreciate each other a little more. As with most collective endeavours, those of us working in HIV prevention probably all underestimate each other's contributions. We see what we do, but get only the occasional glimpse of the effort other people put in. I would like to formally thank my colleagues at Sigma Research on whose work I have heavily drawn for this talk.

Many of you will know I'm a big opera queen. At the opera the audience usually applauds before the performance starts. Often when I take people to the opera for the first time they ask, "What are we applauding for, they haven't done anything yet?" This is wrong. The artists have already done

an enormous amount of work just to be there, and we are applauding to thank them for the work they have already put in.

So, I applaud you for the work you have already put in. I look forward to good performances from you all at this conference. And I thank you for a future for bisexual men and gay men that will be better than it would have been had you not acted. Thank you for your attention.

Notes

1. For Figures 1 and 2 the data for the years from 1993 onwards is from Health Protection Agency Centre for Infections and Health Protection Scotland. Unpublished HIV Diagnoses Surveillance Supplementary Tables No. 2, 07/4, Table 1, available at <http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1219735626512>. Data for years before 1993 from the same data source in a Personal Communication from Ruth Hunt, 27.2.09.

2. Our picture of the profile of the length of time spent between infection and diagnoses is woefully inadequate, especially given that influencing this profile is the way in which changes in HIV testing policy and practices are hoping to impact on the epidemic.

3. The nation has certainly failed to meet the collective target of a 25% reduction in national HIV incidence by 2007 as set by the *National Strategy for Sexual Health and HIV* (Department of Health) in 2001.

4. In the first part of the two part documentary *Stephen Fry: HIV and Me*, written by Stephen Fry, produced and directed by Ross Wilson, broadcast on BBC2, 2.10.07.

5. Described most recently in the UK by Elam G, Macdonald N, Hickson F, Imrie J, Power R, McGarrigle C, Fenton K, Gilbart V, Ward H, Evans B (2008) Risky sexual behaviour in context: qualitative results from an investigation into risk factors for seroconversion among gay men who test for HIV. *Sexually Transmitted Infections, 84(6)*, 473-477.

6. *The Telegraph*, 23 December 2008, "Pope says humanity needs 'saving' from homosexuality".

7. *Media Guardian*, 6 June 2006, "BBC accused of homophobia over Moyles' remark"; *BBC News Online*, 21 May 2007, "Clarkson rapped over 'gay' jibe".

8. For a recent literature review demonstrating this see King M, Semlyen J, Tai SS, Killaspy H, Osborn D, Popelyuk D and Nazareth I (2008) A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8, Article 70.

9. See Keogh P, Reid D, Bourne A, Weatherburn P, Hickson F, Jessup K & Hammond G (2009) *Wasted opportunities: Problematic alcohol and drug use among gay men and bisexual men.* London: Sigma Research. <http://www.sigmaresearch.org.uk/files/report2009c.pdf>.

10. See Bourne A, Dodds C, Keogh P, Weatherburn P & Hammond G (2009) *Relative safety II: Risk and unprotected anal intercourse among gay men with diagnosed HIV*. London: Sigma Research. <http://www.sigmaresearch.org.uk/files/report2009d.pdf>

11. The task of auditing the NHS spend on HIV services is complex and onerous and made more difficult by a lack of coordination and the limited transparency of NHS commissioning units. In 2001-02 the NHS in London (where half of the countries new infections occur) received £19.2 million for the HIV prevention needs of all Londoners (AIDS Control Act reports 2002). In 2008 we doubt that more than £4 million was invested in HIV prevention activity across the city.

12. Rose G (1992/2008) *Rose's Strategy of Preventative Medicine*. Oxford: OUP. I would like to thank Yusef Azad for pointing me at this book.

13. *Jim'll Fix It* was a BBC television programme aired between 1975 and 1994 in which children (and occasionally adults) would write in wishes to Jimmy Saville who would arrange for them to become reality. Investing only in sexual behaviour change services for HIV prevention is like leaving *Jim'll Fix It* to deal with child welfare.

14. In a recent comprehensive review of HIV prevention needs and services in London carried out by MedFASH, the costs of interventions were kept confidential to the CEO's of the PCTs, being deemed too commercially sensitive. See <www.medfash.org.uk/publications/documents/London_sexual_health_service_mapping_report_PUBL_ONLINE.pdf>

15. See Ellis S, Barnett-Page E, Morgan A, Taylor L, Walters R and Goodrich J (2003) *HIV prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission* (London: Health Development Agency) <www.nice.org.uk/niceMedia/documents/HIV_review.pdf>; and its update by Downing J, Jones L, Cook P and Bellis M (2006) <www.nice.org.uk/nicemedia/pdf/HIVEvidenceBriefingUpdateFinal.pdf>; also see Medical Foundation for AIDS & Sexual Health (2005) Recommended standards for sexual health services (London: MedFASH) <http://www.medfash.org.uk/publications/documents/Recommended_standards_for_sexual_health_services.pdf>.

16. At <http://www.redcross.org.uk/standard.asp?id=43368>, accessed on 27.2.09.

17. In the UK 75% of new HIV infections occur during sex between men and about half of the men acquiring HIV this way are aged over 30 years. Health Protection Agency Centre for Infections and Health Protection Scotland. See HPA's Unpublished HIV Diagnoses Surveillance Tables No. 78, 08/1, available at <www.hpa.org.uk/infections/topics_az/hiv_and_sti/Stats/HIV/NewDiagoses/Nationalnewdiagnoses.htm>.

18. The BCS is carried out by the British Market Research Bureau on behalf of the Home Office. One purpose of the BCS is to "identify those most at risk of different types of crime". Although sexual minorities have long been thought to be disproportionately victimised across a range of crimes, the BCS did not ask a sexual identity demographic until the 2008 survey, thus precluding the possibility of identifying this sexual minorities as most at risk. See <www.statistics.gov.uk/ssd/surveys/british_crime_survey.asp>.

19. A survey of student bodies generating information "used by health authorities to inform health needs assessment and health care planning, and by schools to promote health education programmes, as well as in class work across the curriculum." See <www.sheu.org.uk/index.htm>.

20. This situation is set to radically change with the development of a sexual identity question by the Office for National Statistics. See <www.ons.gov.uk/about-statistics/measuring-equality/sexual-identity-project/index.html>.

21. I have been unable to find the source for this quote. It is not in *Enquiry Concerning Human Understanding* (1748) and I suspect it may be a case of cyber-misattribution.