abstained from sex immediately after their diagnosis, for periods ranging from a few months to two years, with a return to sex coinciding with a return of confidence and self esteem and a greater knowledge of the risks involved. Almost all participants observed that the frequency with which they had sex had declined since their diagnosis. Indeed, five men reported that they had not had a sexual relationship since their diagnosis.

We are aware that the self selected nature of our sample may have biased the results obtained. Our study strongly suggests, however, that the sexual practices of many HIV positive homosexual and bisexual men may not correspond to those described by Catchpole and colleagues. Nevertheless, we agree with the authors' contention that their data highlight the need for more effective health education messages, and we have found that this need was also expressed by the patients we surveyed.

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Several reasons exist for failure of health education message

EDITOR,—M A Catchpole and colleagues report the continuing transmission of sexually transmitted diseases among homosexual and bisexual men infected with HIV-1 who were attending genitourinary medicine clinics; this indicated that a quarter of this group was practising unsafe sexual behaviour.[1] Self reported data on sexual behaviour gathered from HIV positive men in our clinic support these findings. Almost two thirds (221) of our sample of 349 reported having anal sex; among 155 men who responded to a question about condom use, 59 reported that they either used condoms inconsistently or never used them for insertive anal intercourse with their regular partners, while 40 said that this was the case for insertive anal intercourse with casual partners. A substantial minority (45 men) perceived the maintenance of safer sex as a problem.

There is now an extensive literature on the factors associated with unsafe sexual behaviour. This shows that accurate information and access to condoms alone are not sufficient to ensure safer sexual practices and that personal and interpersonal variables are important influences.[2] There is evidence of the effectiveness of cognitive and behavioural interventions to help those who have difficulties in adopting or maintaining safer sex,[3] and in our centre we have introduced a risk reduction service, which translates research evidence into practice and is offered to all people, particularly those who are HIV positive.

We agree with the authors that there has been a failure to deliver an effective health education message to those who are already infected with HIV. The reasons for this include the assumption that all HIV positive people will refrain from unsafe sexual behaviour, fear of further stigmatising those with the infection, and anxieties among health care staff that discussing safer sex with HIV positive people is inappropriate and may deter them from seeking medical care. It is important that, whatever the difficulties, we do not fail to help HIV positive people to protect themselves and others against genital infection and the further transmission of HIV.

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HIV infection must be destigmatised

EDITOR,—M A Catchpole and colleagues report that the current system of voluntary confidential HIV testing in genitourinary medicine clinics in England and Wales is failing to identify a substantial proportion of patients with HIV infection and that many patients who are identified as HIV positive do not adopt or sustain safer sex practices.[1] These findings have major policy implications. Should routine testing for HIV be introduced in genitourinary medicine clinics in England and Wales? Would this help to identify a larger proportion of the population with HIV infection?

Mandatory HIV testing at genitourinary medicine clinics has been carried out in Hungary since 1988 and is considered by Hungarian public health officials to be a highly effective component of the HIV prevention programme.[2] Whereas only 30% of all HIV tests in Hungary are carried out mandatorily (the rest being voluntary), the National Institute of Hygiene estimates that these tests account for 80% of positive results. Positive results are followed by intensive counselling and contact tracing. Infected people are offered high quality medical treatment, psychosocial support, and welfare assistance when these are needed. Most importantly, perhaps, routine testing for HIV infection seems to be widely accepted in much the same way that screening for syphilis is. Opportunities to object to the testing programme exist but have not been exploited even by the groups most closely affected by the programme.

Conversely, the introduction of routine HIV testing in England and Wales could well trigger a chain of ultimately counterproductive events. After 15 years of the control of AIDS being based on voluntarism the introduction of routine testing would almost certainly inspire vigorous opposition. At least some people with suspected or confirmed sexually transmitted diseases would avoid going to genitourinary medicine clinics for fear of being tested and identified as HIV positive. These people, with undetected and untreated sexually transmitted diseases, would then be at increased risk of transmitting HIV.

Moreover, Catchpole and colleagues' findings suggest that, even if routine testing were introduced, this would not of itself result in reduced transmission. Informing people that they are HIV positive is no guarantee that they will consistently adopt safer sex practices.[3,4]

What these findings point to is the urgent need for new approaches that destigmatise HIV infection while providing encouragement to people to accept responsibility for protecting themselves and their partners.

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Sexual behaviour of homosexual men with and without HIV infection differs

EDITOR,—M A Catchpole and colleagues suggest that there has been a failure to deliver effective health education messages to those at highest risk of acquiring HIV infection and those who have already been diagnosed as infected with HIV.[1] This generalisation does not take into account nuances in the behaviour of the two subgroups. Evidence suggests that considerable differences in sexual behaviour exist between homosexual men at high risk and those who are already infected with HIV. Recent data on gonorrhoea from Brighton confirm this behavioural difference.

The number of cases of gonorrhoea in homosexual men attending the department of genitourinary medicine in Brighton fell dramatically from 70 in 1993 to 35 in 1994 and 36 in 1995. Among homosexual men infected with HIV, 13 had gonorrhoea in 1993, seven in 1994, and seven in 1995 (1 in 5 in all three years). In 1995, 24 of 29 men not infected with HIV acquired gonorrhoea through unprotected oral sex under the misconception that the practice is safe. By contrast, five of the seven men with HIV infection acquired the infection through unprotected active and passive anal sex (three rectal and two urethral). The pattern was similar in the previous two years.

Clearly, a substantial majority of homosexual and bisexual men not infected with HIV are well informed of the risks of unprotected anal sex and behave accordingly, although they are misguided, at least as far as other sexually transmitted diseases are concerned, about the safety of unprotected oral sex. By contrast, a substantial number of homosexual men who are infected with HIV seem to ignore safer sexual practice. Education programmes should address this