The show the tables proportions reporting anal intercourse in the preceding year with regular or casual partners in the whole sample. There were no significant age effects on any proportions and no effect of age in group numbers.

All respondents were allocated to one of seven categories (table II) on the basis of their sexual behaviour in the past year. There were no significant age effects when age was taken as a continuous or categorical variable. The length of sexual career (years since first sexual encounter) also produced no significant result (p > 0.15).

Young men remain at risk of HIV transmission, but they are not more likely to have unsafe sex (on a number of measures) than older men. Unsafe behaviour occurs across the age range. Given the fact that homosexual contact remains the most common source of new HIV infections, the need for targeted campaigns for all gay men remains immediate and pressing.

Reference their contention that antibody levels in the months after seroconversion are too low for salivary detection and do not indicate the duration of any such period. Methodologically, the choice would be between reduced compliance and reduced sensitivity.

We await with interest the speedy, public dissemination of the findings of the investigation into the incident at Glenochil: they are globally important. In the interim we suggest that an urgent response to safeguard individuals without complementary epidemiological surveillance may have been misinterpreted by inmates and thus fail to achieve the high compliance that would be required to interpret the incident at Glenochil.

**Risk of HIV infection in homosexual men**

**Editor,**—A recent paper from the Communicable Disease Surveillance Centre has been widely interpreted to show that younger homosexually active men are more at risk from HIV infection than older men, although the claim has subsequently been questioned by the first author (B Evans, personal communication). Evidence from clinic and surveillance data is subject to a number of biases, including differing patterns of presentation at clinics. Claims that younger gay men have more risky behaviour patterns require evidence from sources other than clinics.

On 19 June 1993 an estimated 130 000 men and women assembled in south London after the Lesbian and Gay Pride March. We used the opportunity to distribute short questionnaires on sexual behaviour for self-completion and administration by trained volunteers. Assessment of age trends was made with ANOVA; cross tabulation was by 10 groups (< 21; age pairs to 34; 35-40; > 40); and five year bands (< 21; 21-25, 26-29; 30-34; 35-40; > 40).

In all, 1633 available questionnaires were returned; most (86%) were self-completed (1383). median (mean) age was 28 (30), range 14-72. A total of 91 (5-6%) were under 21 years of age and 485 (29-7%) under 26; 86-2% of respondents claimed a gay identity.

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**Improving uptake of immunisation**

**Mobile children miss out**

**Editor,**—A major finding in Jan Li and Brent Taylor’s article was that uptake of measles, mumps, and rubella vaccination was strongly influenced by uptake of primary immunisation. We conducted a similar study of factors affecting uptake of diphtheria, tetanus, and pertussis vaccine among 367 children born between October 1991 and March 1992 in a deprived, inner city area of London (Bayswater).

Sociodemographic factors and immunisation status were collected from computer and health visitor records of child health status. After 91% (630) children who had moved out of the district were excluded, at age 6 months the uptake of third dose diphtheria-tetanus vaccine was 195/276 (71%) and of third dose pertussis vaccine was 186/276 (68%). Factors that affected diphtheria-tetanus uptake at six months (table) were similar to those affecting uptake of measles, mumps, and rubella vaccine. Also, uptake was lowest among children for whom demographic information was unknown; a high proportion (at least 34/64 (53%) of children with unknown number of siblings and 36/72 (50%) of children whose mother’s age was not known) lived in temporary accommodation.

We calculated that for each variable presented in Li and Taylor’s final table up to 8% of the data were missing. From our findings, it is likely that the groups with missing data contained a high proportion of immunised children from temporary housing. When these children move to other districts, full demographic details tend not to travel with them. As children with any missing data were excluded from the logistic regression model, this may explain why Li and Taylor found, after adjustment, that mobility was not significantly associated with low uptake.

In our study, after logistic regression was used and children with missing data were included, the only variables associated with reduced uptake were immunisation at health clinics (adjusted odds ratio 0.53, 95% confidence interval 0.28 to 1.00) and...