"You've set out the problem. What do solutions look like — and what do you need?"

ANSWERED, IN THREE PAGES

HIV IS THE CONTROL EXPERIMENT.

It is the one condition where this population was actually counted — by ethnicity and by sexual orientation, together, because there was political will and money. **The same men are invisible in mental health, in cancer and in cardiovascular disease. Build the counting once, and it serves all four.**

WHO WE ARE TALKING ABOUT

50-65K

Black queer men in the UK

Census 2021 synthesis · conservative floor 35-40k

25-32K

In Greater London — about half the national total, in your region

48% of the UK Black population · higher LGB rates

88,500

Black residents in Croydon — the largest absolute number of any London borough

Absolute numbers, not percentages, should drive allocation

WHERE WE ARE VISIBLE, AND WHERE WE DISAPPEAR

CONDITION & PUBLISHED SOURCE	ETHNICITY PUBLISHED	ORIENTATION PUBLISHED	INTERSECTION REPORTABLE	WHAT THE GAP COSTS
HIV UKHSA surveillance + PrEP tables	✓	✓	✓	Nothing — and look what that buys. Disaggregating ethnicity within orientation exposes a nine-point PrEP gap the published "ethnic minority" aggregate hides completely.
MENTAL HEALTH NHS England MHA statistics, 2024-25	✓	✗	✗	Two published disparities — 4× detention, 5× suicide attempts — that can never be joined to each other.
PROSTATE CANCER Cancer registration / COSD	✓	†	✗	A £42M trial is being built right now to settle an evidence gap about Black men. It will not be able to see Black queer men inside it.
CARDIOVASCULAR DISEASE CVDPREVENT	✓	✗	✗	Thresholds and recall set for a population we cannot identify inside the data.

† Not a flat absence. Sexual orientation appears in some of these specifications, but it is not enforced, not reliably collected, and has never been published — which, from a commissioner's seat, is the same as not existing. **HIV escapes this by recording probable route of exposure, a clinical variable, rather than sexual identity as a demographic tick-box.** The instrument exists. It is the design that needs copying.

NOBODY IS FAILING. THAT IS EXACTLY WHY NOTHING CORRECTS IT.

Commissioning by single protected characteristic produces a gap that no commissioner owns. **The Black voluntary sector is doing its job. The LGBT+ sector is doing its job.** There is no accountable party for the intersection, so there is no route to funding it — and the same gap now reopens, condition by condition, in every new piece of evidence the state commissions.

FOUR DISPARITIES, ONE POPULATION

HIV & PREP

PrEP need met, 2024
Black 70.0%
white 79.4%

Black gay and bisexual men are the **only** ethnic group below 78% — every other sits at 78–81%, and the published "ethnic minority" aggregate of 77.8% hides it. **It is not refusal.** Once need is identified they start PrEP at 89.9% against white men's 90.5%. The gap is in whose need gets identified: 77.9% against 87.7%, and it has widened since 2021.

Diagnoses fell 6% among white gay and bisexual men in 2024 and rose 15% among Black men. This is why.

MENTAL HEALTH

262 vs 66 per 100,000
CTOs at 8.5×

Black or Black British people are detained under the Mental Health Act at nearly four times the White rate, and issued Community Treatment Orders at 8.5 times. Separately, Black gay and bisexual men are five times more likely to attempt suicide than white gay and bisexual men.

Both published. Neither joinable. The 2023–24 psychiatric morbidity survey could not report by ethnic group at all — samples too small.

PROSTATE CANCER

1 in 4 vs 1 in 8 diagnosed
1 in 12 vs 1 in 24 dying

Black men's lifetime risk against white men's. **But survival after diagnosis does not differ by ethnicity** — the excess is driven by incidence and by everything that happens before diagnosis, which is precisely where a community programme can act.

March 2026: the screening committee acted for BRCA2 carriers and deferred on Black men, citing "ongoing uncertainty".

CARDIOVASCULAR DISEASE

+47% hypertension
12% vs 6% unwarned

Among 8,500 adults tracked for thirty years on the South London Stroke Register, hypertension was 47% more prevalent in Black African and 29% in Black Caribbean patients than white. **12% had their stroke with no prior risk-factor diagnosis, against 6%** — and NHS Health Checks start at 40, which the authors say may be too late.

Thirty years of data from your own region. Orientation appears nowhere in it.

ONE POPULATION. ONE COHORT. ONE DATASET. FOUR CONDITIONS.

This is not scope creep — it is the efficiency argument made concrete. The expensive part was never the care; it is the infrastructure that makes an invisible population countable at all: specialists inside institutions, consented data collection, and the governance that earns disclosure. Built once, every condition after the first rides on it. And because the referral team maps how men move through existing systems, patterns surface fast enough to act on — **nobody is told to come back in five years, when the evaluation is ready**.

WHY FOUR CONDITIONS COST LESS THAN FOUR PROGRAMMES

£60	+£10	+£10	+£10	£90
PER MAN / YEAR	MARGINAL	MARGINAL	MARGINAL	PER MAN / YEAR
Mental health + all the infrastructure	**HIV**	**Prostate cancer**	**Cardiovascular**	**All four** £7.50 a month

THE PROGRAMME, IN FOUR MOVES

SPECIALISTS
Ten Black queer specialists on 18–24 month reform posts across six sectors, plus a referral team mapping how men move through existing systems

CARE
1,825 men into culturally competent therapy over five years, allocated by network position; London hub, three spokes; 200 trained a year in first aid

CULTURE
The BLKOUT magazine — four guest editors a year, 28 contributors, with audio and film, on a platform locked at £0 permanently

EVIDENCE
The comparator dataset that does not exist, plus the variables nobody records: which intervention, and why people stop

NOT A STANDING START

88
members of BLKOUTHUB over six years — 79% joined for connection, not services or information

36
Black queer men through Ivor's Compass at Stanley Arts, April 2026 — delivered and evaluated

1ST
published UK synthesis of ethnicity × sexual orientation population estimates, open to correction

£0
of this programme funded to date — the platform, research and governance already exist and run

WHAT WE NEED

£0

Within your own gift
Highest leverage here

WHAT ONLY YOU CAN GIVE

- **Start with TRANSFORM — it is being designed now.** £18M has just gone into inviting every Black man in England aged 45–74 into a prostate screening trial, because the evidence on Black men is uncertain. It will record ethnicity. **Add sexual orientation and one trial tells us what no dataset can.**
- **Extend the counting that already works.** HIV manages the intersection by recording probable route of exposure — a clinical variable, not an identity tick-box. Copy that design into mental health and cardiovascular data and the disclosure objection answers itself.
- **Convene it — and name it afterwards.** The gap exists because no single party owns it: exactly the problem convening power solves and nothing else does. A room with the London analysts, the ICBs and both sectors in it is something you can call and we cannot. A sentence in a London public health document afterwards makes it citable, which is what makes a population commissionable.

£2.7M

over three years
£90 per man / year
6-9 months to start

★ START HERE

THE PROVING GROUND — SOUTH EAST LONDON, ALL FOUR

The South London and Maudsley footprint — Croydon, Lambeth, Lewisham, Southwark — holds the four largest Black populations in London and an estimated 7,500–10,500 Black queer men. It is your region, and it already contains the sexual health services where this population is counted, which makes it the one place the join can be built and tested. It crosses two Integrated Care Boards — not a complication but the test: whether resources can follow a population that organises relationally rather than by postcode.

£15.75M

over five years
£90 per man / year

THE FULL PROGRAMME — NATIONAL, FOUR CONDITIONS

35,000 Black queer men. £10.5M carries the shared infrastructure and mental health delivery; £1.75M each adds HIV, prostate cancer and cardiovascular disease.

WHAT £15.75M BUYS

	SHARED INFRASTRUCTURE — SERVES ALL FOUR
£2.5M	Specialist cohort fellowship — 10 posts, 5 years
£1.8M	Referral and advice team — journey mapping, system learning
£1.6M	Consultancy team championing specialists
£1.3M	Governance, deliberation, community accountability
£800k	Platform and digital infrastructure
£400k	BLKOUT magazine — 4 editions a year, with audio and film
£200k	Community-led evaluation and evidence
	CONDITION-SPECIFIC DELIVERY
£1.9M	Mental health — therapy, hub and spoke, first aid
£1.75M	HIV — PrEP need identification, retention, the data join
£1.75M	Prostate cancer — reaching men from 45, TRANSFORM linkage
£1.75M	Cardiovascular — blood-pressure control, not just detection

£15.75M **35,000 MEN · 5 YEARS · £90 EACH PER YEAR**

THE TRADE-OFF, STATED PLAINLY

SHARPER

Mental health alone is one mobilising disparity with a named partner and a delivery record behind it. Easier to fund, easier to explain, and it does not ask a commissioner to own four things at once.

TRUER

Four conditions describes what this actually is — population health infrastructure, not a service — and reaches budgets a mental health ask cannot. It also protects against BLKOUT being read as a mental health intervention, which we are not.

Our recommendation: take the four-condition frame. It is the truer description of the work, and it is the one that matches your remit. We will still make the mental-health-only case where the money is condition-specific — but as the narrower ask, not the real one. If you think that is wrong, your reason will be worth more to us than the choice.

SOURCES FOR THE FIGURES IN THIS BRIEFING

UKHSA — PrEP provision tables 1c; HIV report 2025 (2024 data)
NHS England — Mental Health Act Statistics, annual figures 2024-25
Lloyd et al. — BMC Medicine 2015;13:171, lifetime risk by ethnic group
UK NSC — prostate recommendation March 2026; TRANSFORM expansion 2 June 2026
King's College London — South London Stroke Register, 30-year analysis

DR ROB BERKELEY MBE
Founder & Director, BLKOUT Creative Ltd
Community Benefit Society RS009639
research@blkoutuk.com