

David Regan

[00:00:00]

PARTICIPANT: My name's David Regan, I was born in Liverpool in 1959, grew up in Liverpool and then my family moved out to Kirby, because that's where the jobs were. In the 60s, on a Kirby industrial estate, my dad worked for Hygena, my mum worked for Birdseye frozen foods, very happy childhood, tough area, but had a great time growing up there. Lucky to go to Newcastle University in 1978, and never looked back really. Came to Manchester in 1982 to do my master's degree in community medicine. And yes, there was the academic attraction of the university, but to be honest, it had the best gay scene outside of London at the time, which was also a big attraction if I'm being really honest.

[00:00:51]

INTERVIEWER: Fair enough. So how did you first become interested in health or community medicine?

PARTICIPANT: I think when I did my first degree in psychology, the public health bits of the psychology degree really interested me. I actually intended to do clinical psychology, but I saw an advert for a bursary to do public health community medicine, and that you didn't have to be a doctor, so I was one of the first non-medics to apply to do that course and was successful in getting on it at the university medical school down the road. And became really interested in it, in terms of a professional career, but just in terms of hearing about what was happening to friends and people I knew well.

I remember the Horizon television programme, 'Killer in the Village'. Myself and my best friend from school watched it at my mum and dad's house in Kirby and we thought, "What's this?" and just started to pick up on the information coming out of America. And when I was actually doing my master's degree, it was one of the issues I looked into then, in the early days, Gay Related Immune Deficiency, GRID. All the different names at the time before we heard about HIV, but to be honest in those early days, it felt like it was still on the other side of the pond. And it was only '83 [that we] started to hear more about what was happening in the UK, and being really, really honest, my partner, who I met in 1982 at Hero's nightclub in Manchester, we were together 7 years, he died of AIDS in 1989. He wasn't ill until 1988, so for 6 years, we didn't know. Other friends had been tested in the mid-80s when the test became available, but we didn't know our status at that time. And bizarrely, being very honest again, we were in Monsall Hospital at the time, he had PCP.

I was tested as well, my test came back negative, his test came back positive, and it was a very difficult time. I had been a volunteer at Manchester AIDS Line from '86, so we used to cover the phone lines at Hardman Street. And I think that was where my interest —personal, professional, everything— was very intense, back in the 80s. Looking back, thinking, "I was quite resilient then," in my 20s, tended to not think about things so much, things were just happening all around us, a lot of friends died, my partner died in 1989, friends continued to, you know, die.

1996 wasn't the end of it for me in terms of...even though we had combination therapy after [the] Vancouver conference, certainly up until even 2007, you know, [I] went to quite number of funerals, so...[tails off] And interestingly, in terms of the professional side, I'd been a volunteer with Manchester AIDS Line, and I got a job with South Manchester Health Authority in '89 as the HIV Co-ordinator. So that was when there was a national requirement for every authority to have such a post. I was obviously very passionate about doing something, and that was my first job around sexual health and HIV.

[00:05:17]

But I had worked in Blackburn and Warrington on more generic roles, but obviously wanted to work in the field and helped set up what was the genito-urinary medicine service at the old Withington Hospital. We started from scratch, myself and Dr Penny Chandiok, who was the consultant in GU medicine, we set that service up. Very proud of that, and the council also had the AIDS unit, Mesmac were based here, it was a challenging time because we still had Clause 28, we had the big march in February in 1988, the political context was still difficult, all the stigma and all the issues that seem distant now were very stark, but at the same time, there was a tremendous spirit of togetherness, really.

And out of that time, Healthy Gay Manchester, Black HIV and AIDS forum, Body Positive North West, George House Trust, which followed on from Manchester AIDS Line, that was the time that those organisations became established, really. And I know Body Positive is no longer established, but to see the three other organisations, well, LGBTF now, Black Health Agency, George House, come together to form a consortium to some of the current issues, I never thought I'd see that to be honest, but it's good to see.

[00:07:03]

INTERVIEWER: Maybe we can talk a little bit about that later. That's really interesting. Just taking you back again where you mentioned you saw the Horizon documentary, can you remember, can you describe what the atmosphere was like, politically, socially in the context in terms of this new disease that people didn't know much about? What was the environment like at that time?

PARTICIPANT: When we were in our own bubble, so when we were going to Hero's, Archway nightclub, going out on the scene, you were still quite protected. But in the workplace— I worked in Blackburn. I distinctly remember one of the admin staff saying to me, "Have you had a drink from that cup?" I said, "Yeah," She said, "Oh, oh right, OK." And I knew— Jenny was her name, I said, "Is there an issue?" She said, "I've just seen all this media coverage," And so there was the odd example, it wasn't every day, where you could sense that the real ignorance, the fear of people, the fear of gay men, basically. So you found comfort in your own world.

It's interesting from a work point of view. At Monsall Hospital, we were very lucky, 'cos there were some fantastic clinicians. Director of Public Health at the time, Joyce Leeson, great advocate, really, really speaking up, so it wasn't just lesbians and gay

men, it was some lead clinicians in the city. But the ignorance, and the basic fear and the basic understanding of the infection literally was quite shocking when you look back. And then to go on the phone line at Manchester AIDS Line— I think I was the third intake of volunteers, so it was still quite a small organisation, and we took on those phonelines, and to be fair to people, most of them were ringing with their own personal concerns, but it was everything from, "Someone sneezed next to me, can I catch it?" to people who had obviously put themselves at risk, and you're trying to direct them to services, so there was a lot of...when we set up the helpline, the volume of calls was unbelievable. We were extending the hours of that line, getting more volunteers.

And it culminated [in] 'Don't Die of Ignorance', 1987, the AIDS Week, as they called it on television, where they co-ordinated a set of television programmes across BBC, ITV, and we, Manchester AIDS line, were asked to staff the phones at Granada TV studios, and it was great because the Coronation Street stars, Vera Duckworth, I remember, they were great, actually. They came in, [saying] "You all right?", made us cups of tea. It felt as though that was a watershed of, trying to create, whatever the criticisms of the ad campaign are, it did actually lead to that recognition that there needs to be more public awareness, and actually, I think, after that, things started to— there was still the stigma, I'm not saying that went away in 1987, but it felt like a watershed moment for me in terms of just that coverage, trying to reduce some of the fear. And yeah, it was a key time.

But I'd say through the 80s and most of the 90s, a lot of that fear and ignorance didn't go away, and I remember going on the Clause 28 march in February 1988 and that felt quite cathartic in terms of, yes it was about Clause 28, but it also was about HIV and AIDS, it was about a range of issues. And Manchester felt a great place because there'd always been the history of tolerance and openness, the council had set a good example, it has got its faults, but it did provide some civic leadership and it helped, I think, groups and organisations, to develop, and also we saw the scene expand in the 90s, but in the 80s, it had had a sense of connectivity that I— I don't want to look through rose-tinted glasses, but it was a time of, I think, solidarity and really strong community spirit.

And some good new relationships established, bizarrely, the voluntary and community sector, and some of the clinicians in the city, that made a huge difference. And Manchester, MRI, Withington, and particularly North Manchester General, I think, provided that assurance that there were great clinical services. People didn't have to go to London, they could get the support here, so I think it was a challenging time, but also a time that we saw some really good services that are still here to this day, established.

[00:13:14]

INTERVIEWER: You mentioned Withington as part of that, but going back again, I've heard people talk about, in this project for example, in terms of what you were saying around misunderstandings or ignorance around infection control, there was an example of someone who was quarantined. Do you know much about that?

PARTICIPANT: I do.

[00:13:50]

INTERVIEWER: Because I've only learnt about it through this project.

PARTICIPANT: It was a really- difficult case, that. Mike Painter [who] was the medical officer for health at the council at the time, came to a meeting at Manchester AIDS Line. I don't know all about this. In terms of public health, it was a 2a order. It is used sometimes around TB cases and it's a difficult one, this, because I think I was part of the, "What the hell's happening? This person's been detained against their will." The complexity of it, I think they had, from an infection control point of view, some quite severe open wounds, and I don't think it was done out of civil liberties. There was a balance to be struck between the person's mental state, the physical manifestations, and it was a really difficult time. Looking back, it'd be easy to say [that] the clinician's got it wrong, and they probably did, from a purely 'hindsight's a wonderful thing' [perspective], but it was one of those difficult situations, and it was unfortunate for the person involved, definitely.

When my own partner was at Monsall Hospital, I can't speak highly enough of the staff there, but that was 1984 or -5. Come 1987, '88, things had moved on a lot. So even in that space of time, from having no tests, not really sure, even the clinicians still learning about the issues, and then making those sort of judgements, it was difficult. No-one liked the media coverage of it, obviously. Ideally, they should have been kept under the radar and handled sensitively, but the press got hold of it, and they used it in a negative way. So that was the downside, really.

[00:16:21]

INTERVIEWER: I was wondering if you could say a little bit more about Manchester AIDS Line and what the atmosphere was like, who you were working with. Where was it based?

PARTICIPANT: Joyce Leeson used to direct public health at North Manchester General [Hospital]. Her secretary, Vicky, helped us. She was a volunteer, but helped us get rooms in all different parts of the city. But the main base we used was on Hardman Street, where Spinningfields is now. And that's where we had the phone line and we used the training rooms.

There was a man called James Fishwick, who along with Jill Cowley, who ended up being a counsellor at Monsall, ran some of the training courses, and they were absolutely brilliant. James had been to San Francisco, he'd got friends there, he brought a lot of that information back, and they were better than any course that [laughing] the NHS or others had put on! The volunteer training programme was brilliant. We did roleplays about the types of calls you get, they brought in the clinicians to do some of the [tails off] I remember pictures of people with Kaposi sarcoma, a really in-depth, at least six training sessions before you went onto the phonelines, and also to check that you were OK to deal with everything that would be thrown at you in terms of people's sexual history, what they would tell you, and making sure that you didn't judge on the other.

James had been in Samaritans as well, so I think bringing a lot of that ethos and approach helped, but it was a really...and Paul Fairweather, Paul was one of the founder members, later became a councillor here, but the group of people who'd found it, gradually, the numbers grew and grew and grew. And it was a good time in terms of that community response, but actually, it wasn't one of those times where people sat by a phone waiting for it to ring, there was a real desire for information and no internet, obviously, limited television coverage, poor media coverage, generally, so it was where people got a lot of information.

[00:19:17]

INTERVIEWER: You mentioned that you became HIV Co-ordinator for the authority. Could you say a little bit more about that role, what that involved?

PARTICIPANT: They brought out the AIDS Control Act and there was a recommendation that every health authority area must have an HIV / AIDS Co-ordinator. The role varied, but basically, we had to co-ordinate the provision of services in that local area. So I was covering south Manchester at the time. It was interesting that at the same time, the plans to establish a genito-urinary medicine clinic at Withington Hospital happened at the same time, and so I had a great start to my job because we were setting up a new service.

There were cases at Wythenshawe Hospital, because there were a number of people who had chest conditions, PCP in the main, and they were the specialist units, so I actually did face-to-face work, I had a caseload, there were no health advisors, so I did a lot setting up the testing clinics, did the pre-test counselling, and gave results, so it varied, but I did have a very hands-on operation, although with a case load, running the clinics, setting them up, so it was new role and we all had to make of it and respond to a fast-changing situation, whether it was new drug treatments, new tests, working with our drugs services, setting up needle exchanges, a whole range of local developments.

But for me, my main focus was helping set up the GU clinic and bringing some of the North Manchester clinicians from the regional infectious diseases unit to do clinical sessions at Withington Hospital. Because there was a bit of a tension at the time between genito-urinary medicine and sexual health services and infectious disease and [we were] just trying to make sure that we had an integrated approach to services. And it was certainly true that people admitted to generic wards, whether it

be MRI or Withington or Wythenshawe, didn't always get the best service from a clinical point of view or even from how they felt. We still had some staff and some of the bad experiences.

We tended, certainly on Manchester AIDS Line, to try and direct people. If they were really ill to North Manchester to Monsall, because we knew that the clinical expertise was there and the staff environment was good. They had counselling provision, they had a good team approach. So it was an interesting role, but one that I looked back and thought, "We did a good job." We did have resources, to be fair, despite the current austerity. When I look back, we did have funding to set up clinics, to set up services and start to fund the VCS organisations. There are never enough resources, but we were given money to pump prime and develop services.

[00:23:10]

INTERVIEWER: So you mentioned the VCS organisations. Could you say something about the kinds of organisations that came out of Manchester AIDS Line? Things like Mesmac initially, and Healthy Gay Manchester, Manchester AIDS Forum, Body Positive?

PARTICIPANT: I remember Ian from Mesmac, and apologies, I can't remember Ian's surname, and the council, with the AIDS unit [were] really keen to put money in, and there was big team. We had the Manchester AIDS Forum, which brought all the clinicians, the VCS and other agencies together, [which] the council supported. But I think as Mesmac became more restricted in a council setting, and politics, bureaucracy, and also looking at what happened in London, elsewhere, having an independent voluntary community sector organisation was key.

I remember Evelyn Asante-Mensah coming to see me when I was at Withington Hospital, about establishing the Black HIV and AIDS Forum, and I remember Evelyn and Priscilla from the early days, I remember Jeff Lilley at Body Positive North West. And it was right that everyone wanted to do what they thought was right from where those groups had originated, what they wanted to see happen, and obviously Manchester AIDS Line became George House Trust. I'd stepped back from being a volunteer soon after I got the HIV Co-ordinator role at South Manchester Health Authority, and because of my personal circumstances with my partner, so it was interesting to see how the organisations were all developing, for different reasons.

And I do remember Healthy Gay Manchester because that was very much, clue's in the title, trying to push for more of a preventative approach, particularly around condoms and lube and distribution and information and publicity without the restrictions you could get [laughing] within the council settings.

So it was very much borne out from that, "We could be more—" and I remember Gerard in particular, just recognising that, "Give us a resource, you can step back and we can do what's needed, working with our community," and doing that. And the same with Black HIV and AIDS Forum, Body Positive North West, there were a few key lead people, Eddie, Jeff and others who wanted that support arrangement, and they wanted to remain independent from George House Trust. All the groups, I can look back, not to say that there weren't squabbles, fall-outs, all of that, but they all

were established for different reasons. And at the time, for the right reasons, and I think it reflected the diversity of the city and was good.

[00:26:53]

INTERVIEWER: I was wondering whether you might talk about, if you're comfortable about it, how it was, because I imagine then you were also a carer at the same time. How was that for you?

PARTICIPANT: I got the job at South Manchester in June '89, but Mike, my partner was diagnosed in February '88, and the humorous bit of this, we both, myself and Mike, laughed about this, we were in Monsall Hospital, black-and-white telly, Top of the Pops was on, I think it was the day after we got the results, he was being treated for PCP, and Kylie Minogue was Number 1 with 'I Should Be So Lucky'. So we looked at that and thought, "This is interesting," but the focus was on— because he had PCP, I knew from the AIDS line training that the prognosis wasn't great. So, you start to adapt quite quickly to what's going to happen, and what you didn't know at that time, 3 months, 6 months, however, and things sort of stopped for a bit.

I was lucky, because where I worked at the time in Warrington, it was a generic health promotion job, and my boss at the time [was] Val. I was in a small team, there was Val, Claire and Anne, and I rang up to say, "I won't be able to be in work, I'm not feeling too great, I'll be back next week." Went straight in, [they asked] "What's the matter?" and I told them right away. Now I knew them well enough to say, "Look, Mike's just had a diagnosis," they all burst into tears, gave us hugs and we still meet every year, that group. So I was very lucky to have that work environment to be so supportive and I carried on working at Warrington.

Mike stabilised and we actually went to see his sister in Canada that summer, and looking back, the quality of his life and support that he had from Jill Cowley at Monsall, one of the counsellors, our friends, his family were fantastic, I'm still in touch with them, his mum's 92, we went up to see her with my new partner the other week, his sister from Cannock comes and stays with us, so there's still that strong family connection to Mike's family, and he's got a twin brother as well, still very much in touch with John, so there was a real strong family network, and work was good, so I was very lucky and I could see other friends who were diagnosed around the same time didn't have that same support. And I could manage work, go to work and do that.

And then when I got the job in Manchester in June '89, Mike's health wasn't great. And it was more challenging, really. People said, "How can you do this for your job and have this at home?" And I said, "Well, [00:30:41] [it has to want to do?]," and I can take what I'm doing at home and see it happen and know how it should be, it should be better than this. So it was quite a personal drive to do that. And I look back and think, you know, but I think it's because of the support network, my friend support network, fantastic, family. I was very lucky. I think that helped a lot.

[00:31:16]

And bizarrely, I was then involved in a car accident four weeks before Mike died, lost my kneecap, in hospital for two weeks, so it was quite a— it was in Salford, now Salford Royal, so that final bit was a difficult time but bizarrely, because I wasn't in work [laughing] with my own issues, that the quality time at the end and afterwards was good. And as I say, I was very lucky that— it was two months later after Mike died that I went back to work, so I don't want to say fate played a part, but I would probably have had to have had that time off anyway, and it just so happened [that] I had a physical reason to not be in work.

But I was able to compartmentalise my work role and home, and afterwards, in terms of the cases I was managing at Withington, after Mike died in October '89 onwards, for a few years, I managed it OK. It wasn't every time something bad happened to someone because, again, putting it bluntly, the prognosis for people wasn't great most of the time, so you knew in terms of the people you were seeing what was going to happen. But we started to see better community support. So Mike died in Monsall Hospital, and that was good at that time; it was the right place, the staff were great, it felt the right place, it felt safe, secure. Doctor Dunbar, the clinician, was brilliant in the end of life care stuff with Mike, and he wasn't in pain so I was grateful that he was in that place, but I did see, in terms of my work and people I was seeing through work, we got community services, district nurses, others, so we were seeing more people dying at home, which was positive for them, because that's what they wanted. We couldn't do it all the time, but it started to improve in a good way.

[00:34:05]

INTERVIEWER: Was Manchester, maybe you were saying initially, it was a thing that was 'over there' in the States, in America, and I don't actually know a huge amount about the kind of epidemiology in the UK. Was Manchester known to be a— and I talked to Paul as well and he said initially, Manchester AIDS Line that the calls were really, it was 'the worried well' but then that seemed to change rather quickly and there were more cases.

PARTICIPANT: Yeah. It was definitely in the early days, the volume of calls was the worried well, but you would get the odd call where you knew from what people say, there's a risk here, you direct them to services. You wouldn't force people, [saying] "You must get a test," it was very much, "You can go, you can discuss whether you want a test or not," so it was quite an interesting different approach to testing than we've got now.

It was very much more, "It's your decision, you must consider all the pros and cons." There were all the life insurance issues, there was a range of things, so you left it. You wanted people to get proper, pre-test counselling, face-to-face at a clinic, but through signposting people to those services, there start to be more and more people testing positive, and also what did happen, talk about late diagnosis, it happened with [00:35:44] [?], you just saw more people who present with PCP, with Kaposi, with other conditions, and that was the first time they were getting their diagnosis.

Monsall Hospital went from being the general infectious diseases unit hospital, so it covered TB, scarlet fever, a whole range of tropical diseases, it was also the cystic fibrosis unit there, but more and more of the beds, and they were all single old isolation ward hospital rooms, became treating people with HIV and AIDS. So you saw the numbers being treated increase and also the numbers tested who were positive who were asymptomatic, Bolton Clinic, Withington, you saw those numbers increase. So it was the late 80s, early 90s I think, when we had more resources, because you got funding based through the AIDS Control Act on the number of positive tests, so we saw more of the funding come in for services. There was a bit of a time-lag compared to London, but I think outside of London, it was starting to become the major centre where there was a network of expertise and treatment.

[00:37:21]

INTERVIEWER: You said that your role was quite hands-on, and you had a caseload. Could you take us through some of the ways in which the different technologies changed over time, over the years, in terms of testing, then also in terms of treatment and more recently in terms of prevention, then thinking about PrEP as well?

PARTICIPANT: Complete transformation. When I first helped set up Withington, with test results, it wasn't 3 weeks, but it might have been 2, then we got it down to 1. So the wait between getting a test and getting the result was torturous, really, [laughing] looking back! The advances there are significant. More effort did go into, "Are you sure about this?" The confidentiality issues, I think, are still key across the board, in terms of that governance, but people didn't have the internet! They would often come to services with a range of misconceptions about what was going to happen, what the prognosis would be if the test was positive; some thought they would die in a few—there was a whole range of—just that lack of access to digital information, you had to read it, and often in the press, and it wasn't always of the greatest quality.

So there tended to be more focus on the counselling, support, information side once people presented to services. I think the big change, obviously was the Vancouver conference, 1996, combination therapy. It probably moved slowly at the time, but looking back, where we went from no hope to "Ooh, this could be manageable." I think the sad thing is, though, that too many people still died after 1996, and I include my friends [laughing]. So we still had the fear of not being tested and presenting late and then the treatments weren't as effective, so the view that 'everyone died before '96 and everything was fine after' is wrong, really. I think there was still that knock-on effect for quite a few years, and the fear was still there.

But the Vancouver conference was the big breakthrough. It wasn't overnight, but every year, the clinicians used to go to those international conferences and say, "These new tests, or there's this [that is] new," but that was one where, the combination therapy breakthrough, from what the data was saying, so I think that was a real positive shift. And now, you do see that manageable, long-term condition, less side-effects to some of the drugs, point-of-care testing, more testing opportunities, different messages about testing, PrEP and PEP, so a completely different approach.

I'd still say, though, there's still the stigma around. I've had feedback within some of our hospitals, some of the clinicians and others, some of the views that still persist, so you've still got your great services in many places, but there's still that stigma and ignorance and negative views around, so we've still got some way to go. Generally, it's better, but it's not 100% great across the board, and I think people could still get referred to a service within a hospital and still amongst nurses and others that, "Oh, you know, what's this? Do we need to...", basic stuff. There are still some pockets of bad practice.

[00:42:11]

INTERVIEWER: Like you say, it sounds like there's a huge amount of, well I know there's a huge amount of good practice, but just from some of the interviews that I've done for this project, it still sounds like it can be quite patchy sometimes.

PARTICIPANT: It is, it is.

[00:42:28]

INTERVIEWER: Just as a follow-on from that, we talked about the Vancouver conference being a watershed, but like you were saying, people were still dying, there was still the stigma. Before that, there had been AZT. Had you prescribed AZT in your services as a monotherapy and what did you see?

PARTICIPANT: Mike, my partner, had been on AZT. And there's no doubt, it probably extended the length of his life, in those early days, but it was quite a toxic drug, and really, after about 6 or 7 months, he was having loads of other drugs to cope with the side-effects of the AZT [laughing]. But when people are desperate for anything, it was the only real drug of choice for a while. And I remember Body Positive putting on, not hypnotherapy, I can't really— it was almost like looking at ways of coping with the side-effects of this drug and we were just trying things out to see what would work, to be honest.

But I think the clinicians also felt frustrated because it was one of the only few things they had to offer. So it was not perfect, but it was one of the only things there. And when people are desperate to have something, and we had a role, I'm not the clinician, advising them on the side-effects and what it might do, and people say to you, "What do you think?" and I was thinking, "Well, my partner took it..." So you'd be in a difficult position.

The main thing was just to make sure that people connect with the services, got their bloods checked regularly, and all the tests, the CD4-count tests came on, so there were a range of things that could monitor things better anyway, but it was a toxic drug, but it was the only drug that we had at the time.

[00:45:02]

INTERVIEWER: I think I've covered most of the questions that I had for you. I was wondering if you could bring us a bit more up to date in terms of your role now and

looking back at some of the moments that you remember in terms of sexual health promotion, safer sex in Greater Manchester.

[00:45:32]

PARTICIPANT: I think some of the innovation over the years that [00:45:52] [?] I must give credit to HGM and some of that work, and the work with bars and condom distribution scheme, saunas, and that sort of campaigning work in the 90s. It's strange because at the end of the 90s, I stepped out of the HIV / sexual health work for a good 10 or 11 years, and then when I got a job as director of public health, it was a part of my job, but obviously not the only part. I think they key things is that I'd never see the 3 organisations come together to form the PASH arrangement.

It's not a criticism, it's just the way the system was set up around competition, procurements, all of that. And everyone has a different starting base. But we're in a world of collaboration now. We've got less money, we need to work collaboratively, but not lose our identity and our history, so it can be a challenge. I think that Greater Manchester's led the way in reforming sexual health service, it's had a network arrangement with clinicians across the GU services, we've got cross-charging arrangements in place, so if Tameside residents come into Manchester, Tameside give us the money. We've done our best in difficult circumstances. And there'll be fall-outs, there'll be upsets, but I still think there's a really strong base.

I do think the challenge is —and I've had it this afternoon— there is pressure, there are funding pressures, and the last 7 years of austerity have really made it difficult sometimes. And this is genuinely, as a director of public health, knowing that we've had a 16% reduction in our grant, we can't do everything we want to do, you have to make difficult choices and you have to prioritise, and you know that some of the things that you can't fund any more might have negative consequences down the line.

There's never enough resource. We're doing the best with what we've got. And it's trying to get the prevention work properly funded. It is a chicken-and-egg thing. So how do we put enough resources in prevention to stop all the late diagnosis stuff. It's just a difficult— Because once people come and they're ill, and they come through the door, you have to treat and support them. So it is a difficulty. But I think we should be proud of what we've achieved in Greater Manchester over the years. The odd hiccup here and there, but I think it's we've got some great services, great organisations and the next generation who are passionate about some of the work, and see things differently! And that genuinely [you] have to recognise. What worked for us in the 80s won't work now. The digital stuff, all completely different approach to some of the work we do, and I have to acknowledge it's letting other people bring forward their ideas and not just being an old fogey that says, "Oh, we didn't do that in our day." Things have changed.

[00:49:47]

INTERVIEWER: Just for clarification, could you say, because not everyone will know what the PASH partnership is, can you say what it is and what the rationale behind it is?

PARTICIPANT: PASH, Passionate About Sexual Health is to try and ensure the ten local authorities in Greater Manchester come together as a single commissioner to commission HIV prevention work and support work through a single contract, and that contract has been won by a consortium of LGBTF, Black Health Agency, and George House Trust, who have come together to form PASH. The agencies still have other business, and do their other work, but it's specifically to deliver that programme of work, and hopefully provide some security, stability, for a few years [laughing] at least and to have a consistent approach to what we do in Greater Manchester.

[00:50:55]

INTERVIEWER: We're coming to the end now. Is there anything that we haven't covered that you'd like to say? It could be anything.

PARTICIPANT: I think I'd like to thank all the people who have done fantastic work over the years; people who are no longer here, who we sometimes forget now. It's difficult because I know there's the vigil every year at Pride, but people have different ways of remembering people. We've had the quilt, we've had vigils, we've had a range of things. I just think it's important that with this, that we acknowledge all the people we've lost, or the people who've done some fantastic work and continue to do some fantastic work and will do in Manchester and Greater Manchester. I think the city and the region can be proud of what's happening. We've still got to address the inequalities, the stigma that's still there, but we've come a long way and I think that that will always be the strength of the city, it will respond to challenges generally in a really, really good way. But it's to thank everyone who has worked so hard across all services; VCS, hospitals, clinics, but in particular, to those people who have lost their lives through HIV and AIDS. And many people had a lot of support around them, but unfortunately a lot of people didn't, and we mustn't forget that.

[00:52:32] End of transcript.