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Perspectives on HIV and sexual health in Spain

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Perspectives on HIV and Sexual Health in Spain

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Prologue

"I want you all to see what this disease looks like. It looks like me and it looks like you. The first letter in HIV stands for Human, and I want you all to never forget that"

(Blanca Evangelista in *Pose* episode 6, season 2)

There are many ways to measure the rise or fall of the social, political, and media focus on a phenomenon; the intensity of its presence in cultural productions is one of them. HIV and AIDS faded from view when the chronic nature of the infection became a reality in middle- and high-income countries; at that point, there was also a shift in its prioritization on the political agenda, and this is not necessarily bad news.

At the time at which this report is published, it has been over 43 years since the first diagnosis of HIV infection in the world. In Spain, the first case was detected in October 1981. Many of us who are now in the clinical, political, or management fields have never known a world without HIV. Thus, for many, thinking about the "future" of HIV is not simply about trying to recreate a past that will never return but rather envisioning a future that, based on what has happened in the last four decades, can be shaped in a way that ensures freedom, diversity, equitable access to advancements; the elimination of HIV-related stigma; excellence in the quality of healthcare; and a global outlook governing the HIV situation worldwide.

As we move towards that future, we must incorporate responses to the new challenges that arise. It is often said that each society faces the challenges it is capable of addressing; this transition to new scenarios has been experienced in the realm of sexual health with the achievement of both the chronic nature of HIV infection and the ability to prevent HIV transmission thanks to pre-exposure prophylaxis (PrEP). These milestones, which revolutionized the landscape of HIV infection in our environment, have led to transformations stemming from their

existence: the loss of fear of HIV infection, the increased focus on pleasure in sexual relationships (rather than focusing on avoiding infection), the biomedical centrality in sexual health derived from the previous era's focus, and a politicization of sexual health that, in a way, could be seen as a more palatable version of prior moralization.

All these challenges speak of society through the lens of health. They speak of social and political freedoms, of the need to complicate approaches to sexual health and avoid overly deterministic and excessively biomedical frameworks, and of how to ensure that improvements in HIV prevention and control do not lead to healthcare consequences that diminish their positive effects.

In addition to being an excellent vantage point from which to view the evolution of our society over the last four decades, the HIV pandemic has also been a perfect narrator of global economic and geopolitical balances. There is a thread connecting, on one side, Brazil's universal free treatment program for all people with HIV in the mid-1990s, and, on the other side, UNAIDS Executive Director Winnie Byanyima raising her voice at the opening of the latest International AIDS Conference in 2024 to confront a pharmaceutical company about the need to ensure that intellectual property rights do not stand in the way of people at risk of HIV infection accessing long-acting PrEP. The reason why HIV has been this driving force of global political action throughout history has nothing to do with the virological characteristics of the infection or its greater or lesser sensitivity to medications; the reason is that a strongly organized civil society had the power to move the positions of governments, businesses, and supranational organizations in favor of the health of millions of people. That combined social force is an example for anyone, anywhere in the world, who wants to change things from a position of apparent weakness.

This report addresses what the future of HIV and sexual health might be, what questions are emerging, and what the potential answers could be. Ensuring that what has been learned serves as a tool for the future and that hypotheses progress in the right direction is a collective task that we must advance from every possible angle.

Javier Padilla
Secretary of State for Health

Executive summary

This report compiles and analyses the perspectives of multiple groups about HIV and sexual health in Spain. It also gathers their recommendations to address the current needs from a health, policy, and social standpoint.

In epidemiological terms, the increase in STIs is seen as alarming, although the reduction in new HIV diagnoses and the achievement of the 90-90-90 targets is recognized as a success. Several groups are identified as particularly vulnerable due to political, structural and social factors, particularly migrant GBMSM, trans women, and people ageing with HIV. The interviewees recommend improving the implementation of universal healthcare provisions, as well as developing multidisciplinary research approaches to explore the needs of these groups

In parallel, it is perceived that Spain has undergone and is undergoing a sexual transformation focused on pleasure and reducing the fear of HIV. This transformation has been facilitated by the implementation of PrEP and dating apps. While some have experienced this transformation as liberating, others suggest it has created new challenges, such as chemsex and increased loneliness, particularly among GBMSM. Various groups recommend developing interventions that foster new dynamics of social interaction and address the need for sex education centered on pleasure and care.

The healthcare system faces structural challenges that limit its ability to address sexual health issues: the dominant biomedical approach, which has been effective in improving the survival of people living with HIV, does not address the emotional, psychological, and social dimensions of sexual health. There is a perceived fragmentation and lack of coordination, which hinder comprehensive and equitable care, along with a shortage of training among healthcare staff. To address this, it is recommended to develop training programs that approach sexual health holistically, improve coordination among stakeholders, and increase funding.

In the political and community spheres, there is a growing disconnect between public policies and the realities of the affected populations. It is felt that HIV is no longer a priority on the political agenda, which has weakened institutional responses. Community organizations play a crucial role in providing care for people living with HIV, especially in prevention and psychosocial support, but these organizations are overstretched to a breaking point. The report recommends strengthening the community model by increasing funding, enhancing their involvement in policy formulation and management, and improving coordination between third sector and public institutions to offer a more effective and equitable response.

funding, enhancing their involvement in policy formulation and management, and improving coordination between third sector and public institutions to offer a more effective and equitable response.

Finally, in relation to society, culture and education, this report highlights a widespread belief that there exists a sociocultural crisis that underlies many of the sexual health problems explored. There is a need to generate discursive spaces that foster stronger responses to HIV and sexual health. Specifically, there is a perceived lack of resources and spaces for artistic intervention, which participants recommend addressing. Departing from an understanding of sexual health as a phenomenon with cultural dimensions, the report proposes greater investing in culture and art as effective mechanisms for reflection and creative intervention. Likewise, it emphasizes the need for a renewal in sex education: the current approach is insufficient to respond to the transformations that have taken place in sexuality. It is necessary to integrate the management of pleasure, consent, and a positive view of sexual health into educational programs.

In sum, the report compiles perspectives on the urgency of a more inclusive, coordinated, and multidisciplinary response to the challenges of sexual health in Spain.

Key findings and recommendations

	Key findings	Recommendations
The epidemiology of HIV and other STIs in Spain	• There is a concern about the increase in STIs, attributed to various social and cultural causes. • The main populations vulnerable to HIV are migrant GBMSM of Latin American origin and trans women. • The vulnerability of these groups is explained by flaws in the implementation of the universal healthcare provisions in specific regions and institutional invisibility. • The ageing of people living with HIV and their specific challenges are seen as an emerging issue that requires dedicated attention. • PrEP is seen as a fundamental shift, associated with both an increase in STIs and a sense of personal responsibility.	• There is a need to research the reasons behind the increases in STIs in Spain from a multidisciplinary perspective tailored to the specificities of the Spanish healthcare system. • It is a priority to facilitate access for migrants to the healthcare system and PrEP without legal or cultural barriers. • More research is needed to understand the needs and situations of particularly vulnerable communities. • Considering the ageing of people living with HIV (PLHIV), social and health services, such as care homes, insurers, and caregivers, should be included in discussions about HIV.

Sex and sexuality: a sexual transformation	• Spain has undergone, and is undergoing, a sexual transformation emphasizing pleasure over fear of HIV. • PrEP has had transformative effects, facilitating sexual experimentation and liberation. However, it has also emphasized a biomedical approach to sexuality. • Dating apps have transformed sociability and sexuality, particularly among GBMSM communities. • Chemsex is perceived as a serious problem, with multiple underlying causes. However, the framing of chemsex itself as a "crisis" is contested. • Loneliness and a lack of social support networks are seen as significant underlying causes to sexual health problems. • The sexual transformation has not been accompanied by the necessary transformation in sex education.	• It is important to develop interventions that create social spaces not based upon sex or alcohol or substance use. • The impacts of dating apps in the Spanish context and health are under-researched and required a thorough interdisciplinary approach. • The sexual transformation that has occurred necessitates new approaches to sex education that provide tools for managing pleasure. • Chemsex presents a complex and still poorly understood issue that requires collaborations between institutions and communities.
Sexual health and the healthcare system	• The current approach to sexual health is primarily biomedical and hospital-centered, often neglecting the social, emotional and psychological aspects of sexual health. • Healthcare is fragmented, with multiple institutions lacking coordination and resources.	• It is urgent to develop training programs (both formal and informal) in sexual health and the related socio-cultural competencies. • Coordination between institutions and entities requires a systematic effort to collect data on what services are available and where.

Sexual health and the healthcare system (continued)	• There exist deficiencies in medical training, particularly relating to socio-cultural competencies among healthcare staff. • Stigma related to sexual health and sex is prevalent, affecting both patients and professionals. • The establishment of a specialty in infectious diseases and the transfer of some sexual health care to primary care are both potential future avenues.	
Politics, activism and institutions	• Participants described a growing politicization of sexual health which subjects health promotion activities to political fluctuations. • There is a clear problem with the current funding model, which is fragmented and does not guarantee the longevity of programs or the retention of professionals. • Community organizations exist in competition due to a lack of funding. • There is a declining interest in HIV which has required some community organizations to evolve in their objectives. • There is an interest in upstream policies. Community organizations can contribute to these policies with the knowledge gained in their fight against HIV.	• Consolidate participation pathways that depoliticize sexual health. • Modify the current funding model to ensure the continuity of programs and the retention of professionals. • Encourage collaboration among community organizations, promoting the sharing of talent and professional skills. • Collect, value, and mobilize the knowledge gained in the fight against HIV to address other health issues.

Society, culture and education	• The current context is marked by a “second silence,” which entails the invisibility of HIV and sexual health. • There are suggestions of there being an “identity crisis” underlying phenomena such as chemsex. This crisis is characterized by loneliness and a lack of leisure activities. • Art, literature, dance and theatre serve as engines of social change and can provide essential tools to address sexual health but require new funding models which allow for long-term interventions. • There are significant deficiencies in sex education, partly due to its politicization.	• It is urgent to develop new models of interdisciplinary collaboration in all areas, from research to political participation and artistic creation. • There is a need to analyze the possible existence of an “identity crisis” within GBMSM communities as one of the underlying causes leading to the increases in STIs and chemsex. • It is necessary to promote the generation of discourses on HIV and sexual health through establishing spaces for artistic, literary, and performative intervention and creation. • Social consensus must be fostered regarding the need for quality sex education focused on individual and collective care and wellbeing.
Research priorities	• What are the underlying causes and motivations for phenomena and trends in sexual health, notably the increase in STIs and chemsex? • Conducting rigorous and interdisciplinary research that assesses and characterizes the phenomena of chemsex. What are the motivations, experiences, and contexts of chemsex in Spain? • Investigate the “causes of the causes” of sexual health in Spain, including stigma, loneliness, and the trivialization of sex within its social, cultural, material, and political context. • What is the "identity crisis" affecting GBMSM, particularly migrants, in relation to loneliness, STIs, and chemsex? • How do material and political contexts influence the sexual health experiences of various groups and their effects (such as the commercialization of sociability and dating apps)? • Develop and evaluate specific interventions to facilitate access to sexual health services for vulnerable populations (trans individuals and sex workers), focusing on shared and co-produced approaches.	

Research priorities	• Explore the quality of life of people living with HIV, both in general and in the context of ageing with HIV, and their corresponding social and socio-health needs. • How can we measure the quality of life of people living with HIV? What effects do healthcare cuts have on their health and quality of life? • What is the impact of the implementation of universal access to healthcare laws and other bureaucratic and legislative measures on sexual health experiences and epidemiology? • How do young people engage with sexual cultures and acquire sexual health and sexuality knowledge? How can sex education be improved?

Introduction

Since 2006, the World Health Organization (WHO) defines sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality" and clarifies that " it is not merely the absence of disease, dysfunction or infirmity " (World Health Organisation 2006). This definition recognizes the intersection of emotional, social, political, and material, as well as physiological, realities in the experiences of sexual health. Therefore, it also invites the adoption of interdisciplinary research approaches capable of understanding and exploring the multiple realities of sexual health.

This report arises from the desire to address the absence of the social sciences and the humanities, with few exceptions, from the conversations on sexual health in Spain. At the same time, it is also hopes to serve as the starting point from which new lines of research are opened in plural and community-based ways, generating communities and transdisciplinary conversations.

There is clear urgency: the latest reports on HIV and sexual health in Spain show an upward trend in diagnoses, placing Spain above the European average (Unidad de Vigilancia de VIH 2024; Dirección General de Salud Pública 2023). Sexually Transmitted Infections (STIs), including HIV, continue to be a serious problem. All of this highlights the exhaustion of purely biomedical models and the urgent need to involve other disciplines to understand the multiple realities that shape sexual health in Spain.

In alignment with the Sustainable Development Goals (SDGs) included in the WHO's 2030 Agenda, ratified by the Spainish Government, research in sexual health must be addressed in interdisciplinary terms to “ensure healthy lives and promote well-being for all at all ages” (SDG-3) but also to “Reduce inequality within and among countries” (SDG-10) (Ministerio de Derechos Sociales n.d.).

Sexual health carries a component of stigmatization, both pronounced and unavoidable, which undermines what the WHO, in its 2006 definition, understands as the “positive and respectful approach” that must be offered “to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence” (World Health Organisation 2024b). Only through the social sciences and the humanities, culture, and art, can we effectively address the stigma that exists in our society and hinders effective progress in sexual health.

This report also responds to the proposals outlined in the Strategic Plan for the Prevention and Control of HIV and STIs in Spain (2021-2030) [Plan Estratégico para la Prevención y Control de la Infección por el VIH y las ITS en España (2021-2030)], especially in relation to the principles of "equity" and "complementarity" at its heart (División de Control de VIH and Centro Nacional de Epidemiología del Instituto de Salud Carlos III 2023). To place "the dignity of people with HIV and/or other STIs and/or who are vulnerable at the center" ["en el centro la dignidad de las personas con el VIH y/o otras ITS y/o que son vulnerables"] and, likewise, promote "the creation of a conducive environment for the success of HIV responses" ["la creación de un entorno propicio para que las respuestas al VIH puedan tener éxito"], research must offer a response to sexual health that aligns with the diversity and complexity of practices and actors involved in its experience in our territory (ibid.).

This report offers a first approach to the current context by exploring different perspectives on HIV and sexual health and identifying research priorities. To carry out this report, original interview work was conducted with a group of twenty-one participants who actively address HIV and sexual health in Spain from a variety of areas of intervention, namely, health, political and governmental, academic, activist, artistic, and performative fields. We have had, and deeply appreciate, the support of multiple community organizations and the Ministry of Health, who have opened up their doors and offered us their time. But this report is only the beginning: creating a multidisciplinary and community-based critical mass of research in the social sciences and the humanities requires a sincere and sustained commitment over time. This commitment should fund and value these disciplines for what they are: intrinsic to understanding and addressing sexual health in Spain.

Method

This report is the product of an interdisciplinary collaboration that includes specialists in sociology, anthropology, philology, and medicine.

Data Collection

This report seeks to highlight the perspectives of all the groups working in the field of sexual health in Spain. To achieve this, the research team conducted twenty-one interviews with:

- People who work in the activist and community world
- Clinical staff, mostly medical, who provide sexual health services
- Political appointments and civil servants from the Ministry of Health
- People who approach sexual health from the artistic and performative world

Qualitative, semi-structured interviews were conducted in Seville, Madrid, Barcelona, and Valencia between June and August 2024. The interviews were recorded, transcribed, and anonymized.

Identifying Results and Recommendations

The research team individually analyzed a sample of the interviews, identifying the main themes. Subsequently, an exhaustive analysis of the transcripts of all the interviews was carried out. Between the months of August and September, the research team worked jointly to identify the results, determine the conclusions and recommendations, and draft the final report.

This report focuses on gathering, sharing, and analyzing the perspectives that different groups have about the situation of HIV and sexual health in Spain, identifying points of convergence, recommendations, and future avenues of research. The set of data obtained through the interviews includes knowledge, experiences, perspectives, discourses, and narratives that, together, open a window into the complexity of the field of the response to HIV and sexual health in our country.

Intersections and Connections

This report organizes the results into several chapters, such as perspectives on the epidemiological or cultural situation. These divisions are artificial, made to facilitate reading. All the topics addressed here are necessarily complex and exist at the intersection of the social, political, cultural, and epidemiological and health domains. For example, it is not possible to understand the phenomenon of chemsex without considering its social components (lack of support networks), its cultural components (commercialization of gay sociability, dating apps), political components (creation of crisis narratives), and biomedical aspects.

Findings and recommendations

The Epidemiology of HIV and other STIs in Spain

Key findings:

- There is a concern about the increase in STIs, attributed to various social and cultural causes.
- The main populations vulnerable to HIV are migrant GBMSM of Latin American origin and trans women.
- The vulnerability of these groups is explained by flaws in the implementation of the universal healthcare provisions in specific regions and institutional invisibility.
- The ageing of people living with HIV and their specific challenges are seen as an emerging issue that requires dedicated attention.
- PrEP is seen as a fundamental shift, associated with both an increase in STIs and a sense of personal responsibility.

This chapter considers the perspectives of various groups in relation to the current epidemiological situation. Specifically, it describes the causes underlying the increase in sexually transmitted infections (STIs), including changes in sexual behavior, social processes, and Spain's role as a tourist hub. It also details the decrease in HIV diagnoses. Furthermore, the chapter addresses the particular vulnerability of migrant gay, bisexual, and men who have sex with men (GBMSM), trans women, and people ageing with HIV. Following this, the chapter discusses HIV pre-exposure prophylaxis (PrEP), particularly in its relation to the rise of STIs, and the concept of undetectability. Finally, it examines perspectives on whether Spain is facing a "crisis" in sexual health.

The Epidemiological Situation: STIs and HIV

The relevance of this report is determined by a concerning situation both in Spain and across Europe. STIs pose a growing problem in our region. In the European Union, STIs are on the rise. In 2022, the incidence of gonorrhea in the EU increased by 48% from 2021 and by 59% from 2018. The age group with the highest incidence is between 20 and 24 years old for both men (99.6 cases per 100,000 inhabitants) and women (48.1 cases per 100,000 inhabitants). Women aged 20 to 24 experienced the largest increase in the notification rate in 2022: 63%

compared to 2021 (European Centre for Disease Prevention and Control, 2024c). Similar figures were observed for other STIs like chlamydia (European Centre for Disease Prevention and Control 2024a) or syphilis (European Centre for Disease Prevention and Control 2024d).

The situation in Spain is similar. The latest available epidemiological data confirm an upward trend in STI incidence, particularly since 2005, with sharp increases in gonococcal infection (from 2.91 cases/100,000 people in 2005 to 32.41 cases/100,000 people in 2021) and syphilis (from 3.39 cases/100,000 people in 2005 to 13.97 cases/100,000 people in 2021). The evolution of chlamydia infection is harder to evaluate due to the lack of historical data before 2015. However, the 2021 rates for this infection were high (48.36 cases/100,000 people) (División de Control de VIH 2023). In response to this situation, a senior civil servant from the Ministry of Health argues that STIs have become a major “public health issue” (P9, senior civil servant).

Regarding HIV infection, the situation, in contrast, shows a downward trend in new diagnoses, both in heterosexual men and gay, bisexual, and other men who have sex with men (GBMSM). The trend is also decreasing among heterosexual women, though the decline has been less marked in the past year (Dirección General de Salud Pública 2023). Notably, Spain has met the 90-90-90 targets set by UNAIDS for 2020. Currently, 92.5% of people living with HIV have been diagnosed, 96.6% of them receive antiretroviral treatment, and 90.4% have achieved viral suppression (Unidad de Vigilancia del VIH 2023). These goals are crucial to halt the spread of HIV and improve the quality of life of people living with HIV. These achievements are a point of pride: a senior civil servant acknowledges that in Spain, “we do a good job treating people and achieving undetectable viral loads: we do it very well” (P12).

This situation is compounded by the emergence of Mpox, which has become an STI since 2022 (Membrillo de Novales et al., 2024; Garcia-Iglesias et al., 2022), with over 100,000 cases globally (European Centre for Disease Prevention and Control, 2024b; World Health Organisation, 2024a). In Spain, 97% of patients with Mpox acquired it through sexual contact, 98% of which involved sexual relations between GBMSM men (Ramirez-Olivencia et al., 2024).

The Causes

The people we spoke to offered several possible explanations for these increases in STIs, including changes in sexual behavior (age of sexual debut, number of partners, use of prevention methods) as well as other "social processes." A senior civil servant from the Ministry of Health explains that the rise in STIs "has to do with all social processes, which have already been described for other epidemics, and I don't think it's something that will disappear. It's serious, very concerning, and we have few biomedical tools" (P12).

Spain's context as a geographical and cultural nexus between Europe, America, and Africa, and the importance of the tourism sector in the country, also influence the situation. A researcher and activist explained that Spain is "a tourist country, very exposed to consumption phenomena, sexual practices, and recreational uses" (P15). In fact, the first Mpox outbreaks in Spain were linked to sexual encounters involving international tourists.

Vulnerable Populations

The interviewees identified two particularly vulnerable groups that are overrepresented in new HIV infections: migrant GBMSM from Latin America and trans people.

Migrant GBMSM

Migrant GBMSM from Latin America are a group particularly affected by HIV. A doctor working in HIV care explains that, in their hospital, new diagnoses tend to involve young Latin American migrants, mainly GBMSM. While some had been diagnosed in their countries of origin, many are new diagnoses in Spain: “In my hospital, new HIV patients tend to be men aged 25 to 45, from Latin America” (P14).

The vulnerability of migrant GBMSM lies, according to many interviewees, in the absence of social and emotional support networks, homophobia, and lack of access to PrEP. Regarding the latter, both high-ranking politicians and community agents agree in pointing out the deficient application of the Universal Health System Law (Ley de Universalidad del Sistema Nacional de Salud) in some regions (known as Comunidades Autónomas), complicating easy access to sexual health services, such as PrEP, for people who have just arrived in Spain:

> Among the people getting infected in Spain now, the new infections are overrepresented among GBMSM of Latin American origin, because we are not linking these people to PrEP as soon as they arrive. (P12, senior civil servant)

Furthermore, according to healthcare professionals, managing HIV infection in this population is more complex due to the lack of prior medical histories from their countries of origin. Some patients

> arrive with a diagnosis from their home country, but without reports, follow-up viral loads, or knowledge of the treatments they have received. Here, we have to redirect the situation without knowing their previous history of medications, mutations, resistance, etc. (P14, specialist doctor).

These two factors make migrant GBMSM living with HIV a group that requires special study in the context of the rise in STIs in Spain.

Trans Women

The second most vulnerable group is trans people, particularly trans women, both migrants and Spanish-born. This group faces multiple vulnerability factors, such as involvement in prostitution or the lack of specialist support services. One interviewee highlights the particularly complex situation of "trans women who are also migrants or older Spanish trans women still engaged in prostitution who are super, super vulnerable. These people are in an extremely difficult, very tough situation" (P12, senior civil servant).

Conflicts related to gender and discrimination against trans people, according to some interviewees, may hinder access to STI prevention, information and visibility in relation to prevention activities for this group. An activist explains: "We have no data on trans women in this country because of TERFs. They are an invisible, mistreated group with huge infection rates, and we know nothing about them" (P5). This same activist argues that the invisibility of trans women is a long-standing phenomenon shared with other groups: "Trans women are never a fashionable topic, cis women are never a fashionable topic, bisexual men are never a fashionable topic" (P5).

Ageing PLHIV

Lastly, several participants reflected on the complex situation experienced by people living with HIV (PLHIV) who are aging. They highlighted the issues posed by the development of comorbidities and the need for greater institutional support, both medical and social, which is not always available. The care and social environments of ageing PLHIV are not always accustomed to managing HIV, creating a risk of generating situations of exclusion and stigmatization that require proactive work.

This situation affects other aspects of PLHIV's lives, such as housing, sexual health, mental health, or loneliness, as mentioned by participants. There are also issues with accessing disability/work incapacity recognition, private health insurance, and social care centers (such as care homes).

PrEP Implementation

PrEP is a preventive strategy that involves the use of antiretroviral medications by people who do not live with HIV to prevent infection. A senior civil servant from the Ministry of Health explains that after its dispensing began in 2019, there are currently "almost 25,000 people on PrEP in Spain. The increase is huge. Between 5,000 and 8,000 new users start PrEP every year, and it's working relatively well" (P12). Virtually all the interviewees talked about PrEP in relation to the increase in the incidence of STIs, although they did not always establish a causal relationship. Several participants explained that PrEP has paved the way toward the acceptance and "normalization" of sexual health care, becoming an empowering tool for sexual health care. Thus, a doctor who works in the community setting explains that

"PrEP has been a major breakthrough. [...] It gives us a lot of confidence that the user is more at ease. Now sexual health is very different: we worry when there is an STI, it gets treated, and that's it" (P2).

At the same time, many of the participants highlighted serious issues in the implementation of PrEP in Spain. Firstly, they speak of political causes due to the fragmentation of healthcare among numerous managing bodies, both national (INGESA, MUFACE, ISFAS) and health systems from different regions (Comunidades Autónomas). In this context, there is not only underfunding in the implementation of PrEP but also significant variability in how it has been implemented in different regions (Comunidades Autónomas). As an example, a senior civil servant explained that: “The problem is that the centers that have started providing PrEP do not have additional funding for it. With the resources they already had, they now also have to provide PrEP" (P12).

The problems in the implementation of PrEP cause the emergence of structural barriers that disproportionately affect the most vulnerable populations. Thus, several participants point out that these problems have shaped the current profile of PrEP users: “We are at a point where the collapse is such, and access to PrEP in certain populations is so low that, although it is effective, it is only being effective for the wealthy white gay man" (P5, activist).

The inability to meet the demand for PrEP coexists with a lack of informational campaigns targeting populations vulnerable to HIV. An activist comments that "it's hard to believe that there hasn't been a single public announcement in the media from the Ministry about the existence of PrEP: get informed, you're a candidate if you meet these requirements, etc. Some kind of institutional promotion" (P7).

These two points can be easily related: the lack of promotion of PrEP (what it is, its benefits, who, where, and how to access it, positioning it as a right, etc.) very likely affects the low demand among certain vulnerable populations (such as migrant GBMSM or trans women) who lack information or are unable to access it due to the structural barriers that have been raised in its implementation, such as the fragmentation of the healthcare system, waiting lists, or the poor enforcement of universal healthcare legislation (Ley de Universalidad del Sistema Nacional de Salud).

On a positive note, several participants highlighted the adherence of people on PrEP to routine checks for other STIs. Thus, a doctor working in the community setting explained that, thanks to PrEP,

> now we have many more people doing routine check-ups, whereas before they only did them when they had symptoms. That has changed a lot. People are more responsible and more aware of STIs, so we hold people accountable for their health (P2).

Several of the people we interviewed were aware that, in the media and society in general, there have been discourses associating the use of PrEP with abandoning condoms and,

consequently, an increase in STIs. However, it is important to note that the relationship between STIs and PrEP is significantly more complex. As a senior civil servant explains, while the increase in STIs is partly related to the non-use of condoms,

> The users of PrEP weren't using condoms most of the time before receiving PrEP. That is to say, the people who want to use PrEP, who decide to use it, are already candidates for STIs, just based on their sexual practices. In other words, PrEP is given to people with many STIs, not the other way around (P12).

There are a multitude of diverse perspectives among the interviewees regarding PrEP and its possible relationship with the increase in STIs: it is, therefore, a priority to investigate the consequences of PrEP in the Spanish context.

Undetectable = Untransmittable

"Undetectable = Untransmittable" (U=U) is a concept that refers to the fact that a person living with HIV who is on antiretroviral treatment and maintains an undetectable viral load for at least six months cannot transmit the virus to others through sexual contact (Prevention Access Campaign 2016). The discovery of "U=U" has been identified by several participants as one of the most important milestones in the field of HIV infection, as it frees people living with HIV from guilt, the fear of infecting others, and a significant portion of the stigma. It contributes to their empowerment, allowing them to engage in healthy and pleasurable sexual and emotional relationships. An activist explains that "the mental health of patients with HIV has improved tremendously, tremendously, with the Partner study and with all the studies that have endorsed undetectability" (P18). Another activist explains that both PrEP and undetectability "have taken the fear away from people, which is wonderful, wonderful. For someone like me, my whole life has been a sexual nightmare because of HIV" (P11). However, an HIV specialist doctor points out that "health in people living with HIV is not just about undetectability" (P4). This refers to the possible negative effects of placing too much emphasis on undetectability as the goal of treatment, as there are people living with HIV "who take their antiretroviral treatment but do not achieve undetectability. This can generate frustration or make them think, 'I'm not doing it right' or 'What's wrong with me?'" (P4).

A Sexual Health Crisis

Epidemiological data, as we have seen, shows a clear increase in the incidence of STIs in Spain in recent years, with the exception of HIV. In this regard, the participants expressed differing opinions on whether to define the seriousness of the situation as a "crisis." A senior civil servant argues that "yes, yes, it is clearly an epidemic of STIs" (P9), and an activist also explains that "I think it is a crisis, it's a crisis was bound to happen" (P11). However, other participants do not share this view: an activist explains that "I don't think it's that alarming; the community I work with doesn't have that perspective" (P8). This participant suggests

that, instead, there is a link between the increases in STIs and earlier diagnoses of STIs. This same perspective is shared by a doctor who explains that

> 'crisis' seems perhaps too strong: there is a problem, but we are also diagnosing more; there are contact tracing protocols. Therefore, more people are being diagnosed, which also means the number of cases increases (P4, specialist doctor).

Despite these differences, there is unanimity in the feeling that the current situation is the result of years of neglect of sexual health. There is, however, increasing interest on it currently:

> It's been a problem that has been growing over the last few years to which no one has paid attention, and now that attention is being paid to it [...] it's exploded in our faces. Suddenly, the latest epidemiological surveillance report with data on sexually transmitted infections in Spain is published, it gets covered in the press, parliamentary questions are raised, and then interest begins to rise (P9).

Several interviewees argue that an underlying cause of the current situation is the lack of a social focus. Sexually transmitted infections are seen as an exclusive field of medical science work and research. The lack of interdisciplinary work bridging the social and medical sciences is depriving Spain of a useful tool in solving the problems described in this chapter. Thus, sexual health in Spain is defined as

> a hospital-centered system, even in prevention, that leaves many people behind because it's an impossible barrier to overcome for certain populations, who also happen to have the highest accumulated prevalence, such as trans women or sex workers (P5, activist).

This predominantly biomedical system creates gaps in research and knowledge. Several participants explain that "a lot of social research is needed" (P12, senior civil servant) to understand the needs of vulnerable groups such as trans women, their needs, and situations.

The disparity of perspectives on the current situation of sexual health in Spain, PrEP and its consequences, and the need to better understand vulnerable groups highlight the necessity of studies from a sociological and humanistic approach.

Recommendations:

- There is a need to research the reasons behind the increases in STIs in Spain from a multidisciplinary perspective tailored to the specificities of the Spanish healthcare system.
- It is a priority to facilitate access for migrants to the healthcare system and PrEP without legal or cultural barriers.
- More research is needed to understand the needs and situations of particularly vulnerable communities.
- Considering the ageing of people living with HIV (PLHIV), social and health services, such as care homes, insurers, and caregivers, should be included in discussions about HIV.

Sex and Sexuality: A Sexual Transformation

Key findings:

- Spain has undergone, and is undergoing, a sexual transformation emphasizing pleasure over fear of HIV.
- PrEP has had transformative effects, facilitating sexual experimentation and liberation. However, it has also emphasized a biomedical approach to sexuality.
- Dating apps have transformed sociability and sexuality, particularly among GBMSM communities.
- Chemsex is perceived as a serious problem, with multiple underlying causes. However, the framing of chemsex itself as a "crisis" is contested.
- Loneliness and a lack of social support networks are seen as significant underlying causes to sexual health problems.
- The sexual transformation has not been accompanied by the necessary transformation in sex education.

There is a widespread perception that, in recent years, a sexual transformation is taking place in Spain. This transformation, which affects both the experiences of individuals and community cultures, is characterized by "sexual exploration" and an emphasis on "claiming the right to pleasure," particularly among the gay community (P20, activist). This transformation, which many of the participants associate with the popularization of dating apps and PrEP, has given rise to certain social and sexual dynamics: some are positive, such as the perception that the fear of HIV has been lost and a centralization of pleasure, but others are negative, such as loneliness, the trivialization of sexual encounters, or the increase in problematic chemsex practices.

It is worth noting that most of the interviewees focused their discussions on this transformation in the gay community. An activist, when asked about this emphasis, commented that there has always been a focus on gay men in the field of sexuality and sexual health, while other groups have received less attention: "Trans women are never a fashionable topic, cis women are never a fashionable topic, bisexual men are never a fashionable topic" (P5, activist).

In this chapter, we address this transformation, describing its context and consequences. We also pay special attention to the phenomenon of chemsex, or the "intentional use of drugs to have sex for a long period of time among gay, bisexual, and other men who have sex with men" [“uso intencionado de drogas para tener relaciones sexuales por un periodo largo de tiempo entre hombres gais, bisexuales y otros hombres que tienen sexo con hombres”] (Secretaría del Plan Nacional sobre el SIDA 2020).

Dating Apps

Dating apps, whose most popular examples are Tinder, Grindr, or Hinge, lack a clear definition but, in general, are internet platforms specifically designed to meet other people. In particular, dating apps are characterized by using the capabilities of current mobile phones, such as geolocation and the camera, to facilitate the search for romantic, sexual, or social encounters (Barraket and Henry-Waring 2008).

In the Spanish context, one of the interviewees argued that dating apps are “perhaps the most fundamental change in recent years, and they are not receiving the attention they deserve” (P1, civil servant). The effects of dating apps have been discussed in depth globally, where it has been argued that these apps have reconfigured intimacy practices, offering “new forms of intimacy and emotional connection” (Gibson 2021), new ways to connect, and new rhythms of socializing—faster, always available, and more fluid (Hobbs, Owen, and Gerber 2016; Sobieraj and Humphreys 2021). The LGBTIQ+ communities, particularly gay men, have been the groups that have most quickly adopted these technologies (Miller 2015), incorporating them into their social and sexual cultures (Ahlm 2016).

Another important change that apps have facilitated is the negotiation of HIV: an activist commented that apps have facilitated the normalization of conversations about HIV. Thus, on the apps, “people say they are undetectable or living with HIV; apps make that easier. Ten years ago, it was almost unthinkable for people to say such things openly” (P20, activist). This argument echoes the increasingly important role that dating apps play in health spaces. Numerous authors have commented that dating apps have become essential actors, particularly in the world of sexual health (Garcia-Iglesias et al. 2024): some apps disseminate educational information about HIV or PrEP, or contain filters and fields in profiles to include information about the user’s sexual health. At the same time, apps also serve to facilitate conversations about sexual health before sexual encounters (Race 2015).

Perceptions of PrEP and Condoms

As we wrote in the first chapter, PrEP refers to a preventive strategy that involves the use of antiretroviral drugs by people who do not live with HIV to prevent infection. PrEP exists, beyond being a chemical compound, in a social context that determines its effects (Auerbach and Hoppe 2015). A Spanish activist and researcher we interviewed commented that "the

condom is not good or bad, methadone is not good or bad, PrEP is not good or bad. They can be used in many ways, better or worse, and it depends on how the State, professionals, and users use it" (P15). It is therefore important to consider what perceptions exist about PrEP and its context in Spain.

A central government civil servant commented that the “discourse of PrEP as one strategy among many” has not “caught on” in society or Spanish institutions (P1). This participant refers to the view of PrEP as one more tool of combined prevention, which includes biomedical elements (HIV treatment, condoms, etc.), structural elements (rights protection, fight against stigma), and behavioral elements (education and support programs). A Spanish activist argued that part of the problem was a vision of combined prevention that is too-biomedical, which also influences how PrEP has been adopted:

> When we talk about combined prevention and PrEP, we’ve stuck with the medical aspect, but what are we doing with all the structural changes that need to happen so that people can live better? Where do I talk about poverty? That is also combined prevention (P21).

In this sense, the activist points out that PrEP has reinforced a biomedical approach to sexual health, creating a “population that is perfectly controlled with its treatment cascade, but where there is no space to talk about homophobia or community knowledge” (P21).

One of the most interesting points in conversations about PrEP is how its relationship with condoms is perceived: there is, in general, a perception that PrEP has led—mainly among gay men—to an abandonment of condoms, despite the fact that, unlike condoms, PrEP does not protect against sexually transmitted infections other than HIV. Thus, an HIV specialist doctor commented that, with PrEP, “people are left unprotected from other infections when they don’t use condoms, because they’ve lost the fear of HIV” (P14). This view suggests that STI prevention requires people to have "fear" of HIV as motivation to use condoms.

The perception that PrEP has alleviated some fear related to HIV and that, in turn, this has allowed people to stop using condoms is also shared by several activists. One of them explains the following: “Who likes to use condoms? We used them out of fear of HIV or transmitting it [...] but it was always a matter of survival. Now we have other technologies that allow us not to use them” (P20). Another activist also suggests the same thing, commenting that the condom “you use it while you have no other choice, but as soon as you think it’s safe, you take it off” (P19).

The main issue, however, is how this fear of HIV is perceived: as a necessary element for STI prevention or as a problem to be solved. In this regard, an activist explains the following:

> Health authorities keep talking about how the fear is gone [...] It’s wonderful: we no longer die of anxiety! [...] It’s as if there had to be fear, it seems like they want there to be fear. Do we have to go back to the discourse of the eighties, blaming people? [...] With everything we know, we can’t go back to moralizing (P5).

This activist suggests that, with new knowledge and tools related to HIV, the notion of "fear" as prevention is unnecessary: it imposes a moral and individual framework on what are essentially social problems and, moreover, causes deep anxiety in vulnerable communities. Beyond this, these discourses construct STIs as a reason for 'fear,' generating stigma.

One perception is that PrEP and condoms don't need to be antagonistic: a doctor working in the community with gay men commented, for example, that "for the older person who lived through that pandemic, seeing people die, PrEP has been a liberation" (P2). But that liberation doesn't always mean abandoning condoms: "Even if they continue using condoms, they feel much safer and enjoy sex more" (P2).

Just as this doctor mentions PrEP as a source of "liberation," others highlight other positive effects of PrEP. For example, one describes how PrEP has created new spaces to talk about sexual health: "PrEP provides the opportunity to approach sexual health: not just giving you a pill but having a space to talk about sexual health, identify problematic situations, and create more comprehensive services" (P20, activist). Likewise, this activist commented on the effects that PrEP has had on people living with HIV: "It's been a revolution for those of us living with HIV, a relief from the burden we had: we stopped being responsible, being vectors of infection as doctors told us" (P20). In general, there is a perception that PrEP has contributed significantly to the sexual transformation we discuss in this chapter, as "it has generated a greater approach to the management of pleasure" (P20, activist). This activist gives more details about this transformation:

> Before, sex was very focused on condoms and serological status, and now it's not. Preventive measures are stated, shared, communicated, but they're no longer the focus (P20).

Talking about Where we Hurt: Chemsex and Loneliness

The sexual transformation discussed in this chapter, facilitated in part by dating apps and PrEP, has not only had positive effects, such as a liberation from fear or a move towards sexual experimentation centered on pleasure. It is necessary, as an activist in Madrid argues, to "talk about where we hurt, without fear of being judged. It's like AIDS: silence equals death. If we don't talk about the problems the community has, we can't solve them" (P8, activist). These "problems" that the community—most often referring to the gay community—faces are interconnected, but generally, they focus on chemsex and loneliness.

Chemsex

Throughout the interviews, there was a sense that chemsex has gained some centrality in gay culture, with one activist commenting that,

> in the dating apps, in the culture, a discourse has been generated in a humorous tone, as funny group knowledge, but information about its impacts and consequences is not circulating. When someone has a problem, when a friend dies, that's not talked about (P15).

Behind this "funny" discourse lies a complex and not always well-understood reality.
Although there is abundant research on chemsex, this report focuses on how this phenomenon is perceived among the interviewees. In particular, several participants commented that the central issue with chemsex is not substance use itself but that "you are doing it not from a position of freedom, but driven by something [...] by emotional, self-esteem, or social deficiencies" (P19, activist). That is, chemsex highlights a series of underlying problems and contexts more complex. Throughout the interviews, several factors underlying chemsex were identified, all of which are necessarily interconnected.

On one hand, it was mentioned that dating apps have replaced public leisure spaces, coinciding with the closure of "pubs, cinemas, nightclubs," generating a move toward "private homes" (P19, activist). At the same time, a sexualization of leisure among gay men was described, with commercial leisure circuits and industries (P12, senior civil servant). In this context, an HIV specialist doctor who works with chemsex explains that

> much of what we have in the world of gay, bisexual, and men who have sex with men's leisure and culture is linked to sex, to the body. Outside of that environment, many men don't have friends, they don't have leisure activities (P4).

This doctor describes a process where gay sociability and leisure have become associated with sexual practices, generating a lack of spaces and social dynamics outside of sex. Another activist argues this in relation to chemsex, pointing out that certain groups—such as newly arrived gay migrants to Spain—lack social and support networks, and for them, "it's easier to find a chemsex session [encounter] than to meet friends to go to the movies or eat." This activist continued: "for many people, entrance into chemsex is linked to a feeling of loneliness, a lack of social support networks" (P15, researcher and activist).

In terms of the impacts attributed to chemsex, there are concerns about "the transmission of STIs, but also in terms of mental health, addiction, and crisis situations" (P15, researcher and activist). Furthermore, if loneliness is seen as a contributing factor to chemsex, it is also understood as a consequence. An activist commented that chemsex creates "a false sense that you're living a healthy social life," but in reality, it only exists through substance use (P11, activist). When the encounters end, "people leave, and people are just as alone, but now with the comedown from the drugs" (P11, activist).

Lastly, one of the major concerns related to chemsex are issues of consent. Numerous participants—mainly activists and doctors in direct contact with people engaging in chemsex —explained that their clients or patients describe situations where, in chemsex, there may be a lack of clear consent, and in some cases, even rape, as well as power dynamics and coercion related to who provides the drugs or the venue for the "session" (P4 and P6,

activists). These same users or patients, however, do not always recognize these issues as such and describe them as normalized within the context: “You enter there, and you’re in for everything” (P4, doctor).

During the interviews, several observations emerged about possible solutions to chemsex, including organizing spaces and social groups not based on alcohol or sex (P6, activist). However, on a more structural level, several participants highlighted the need to approach chemsex not at an individual level but by giving people “tools to manage pleasure” (P19, activist) through sexual and emotional education. According to the participants, solutions to chemsex necessarily require understanding the multitude of social, cultural, political, and material dynamics underlying it.

Finally, it is worth noting that there are several perceptions of chemsex itself. Although there are abundant national and international narratives that approach chemsex as a crisis, this perception is not always shared by the participants. Thus, a government civil servant argued that “the emphasis on chemsex seems disproportionate to me [...] There’s no need to problematize chemsex as if it were the main issue in HIV prevention” (P1). Moreover, this person argued that the emphasis on chemsex could contribute to ignoring other problems: “If 7 out of 100 men practice chemsex, it’s a problem, and we need to find a solution, but why don’t we look for a solution to the fact that 40% of GBMSM have experienced anxiety symptoms at some point in their lives?” (P1).

Another activist, working on chemsex, argued that there are different perceptions of the severity of chemsex in different groups:

> On part of the community organizations, the discourse is often that not all chemsex is problematic [...] but when we talk to professionals working in certain spaces, such as hospitals, their perception is different because they are seeing people in crisis (P15, researcher and activist).

In any case, there is a general consensus on the risk that crisis narratives around chemsex, if not considered with the necessary complexity, may lead to discourses that once again associate "homosexuals, vice, prostitution, and drugs” (P19, activist).

Loneliness and Trivialization

Beyond chemsex, several of the interviewees identified loneliness and the trivialization of sex as other consequences of the sexual transformation. On the one hand, an activist suggested that one of the biggest problems is “loneliness, not having connections. Not having created a network that can support you” (P21, activist). This unwanted loneliness, they argue, is associated with many dynamics. Thus, they explain that—in their experience with people living with HIV and substance use—their “networks are lost due to substance use, but also due to HIV. And in the case of people belonging to LGBT groups, networks have been lost or have not been firmly built” (P21, activist). In some cases, those networks have not been built

or maintained due to the prevalence of homophobia and stigma. On this point, an activist working in a peer program with people newly diagnosed with HIV explains:

> LGBT people can't find affection, sometimes because they are still in the closet. There are a lot of people still in the closet. [...] I engage firsthand with people when they get their positive result, and they don't have a single gay friend, a person who is HIV positive and doesn't know anyone who's gay; they've got a huge problem (P11, activist).

Finally, and here we link with the chapter on culture and society, loneliness is also perceived as a product of what is seen as the trivialization of sexual relationships, also as a consequence of the many social, political, cultural, and material dynamics identified in this report. An artist whose work focuses on HIV argued that "society is becoming more and more sexualized, sex has been trivialized with apps and social media; but at the same time, health is not being taken care of" (P17, artist). Another person, a doctor specializing in HIV and STIs, reflects on this: "I'm not sure to what extent trivializing any kind of sexual encounter is part of what we're living through" (P4, doctor). Regarding this argument of trivialization, we, the authors, emphasize the need to be particularly cautious: there is a long and problematic history of understanding the forms of sociability and sexuality popular among sexual minorities as deficient, inferior, or less significant than those assumed among the heterosexual population (such as monogamy). On the contrary, there is abundant research arguing that practices such as casual or anonymous sex can be meaningful and important as a way of socializing (Dean 2009; Delany 1999; Rubin 1999). A more nuanced view should consider the diversity of experiences that converge in gay sociability institutions from different social positions and ways of experiencing sexuality.

In this chapter, we have described the perception that a sexual transformation focused on pleasure has occurred—or is occurring— in Spain. In part, this transformation has been attributed to the popularization of dating apps and PrEP. Although this transformation has allowed the pursuit of pleasure to be re-centered over the fear of HIV, it has also been associated with the issue of chemsex, loneliness, and the trivialization of sexual encounters.

It is necessary to reflect on the interrelationship of all the phenomena we describe in this report: this sexual transformation cannot be understood without considering the material and political contexts (and changes) that frame it, such as migration dynamics and the lack of sexual and emotional education. We therefore call to avoid narratives that focus on individual trends or specific communities as troubled. Many of the problems identified here affect men who have sex with men, but they are not solely their problems: they are structural problems that require structural solutions. In this sense, we also call for reinforcing vertical and horizontal research on exclusion and inequality. Finally, we recall the quote from an activist calling for education in "tools to manage pleasure" (P19). As we will detail further, it is apparent that the transformation of sexuality has not been accompanied by a transformation in the people's sexual and emotional education: the popularization of dating apps, the availability of PrEP, or the increase in chemsex require that we provide the population with new tools.

Recommendations:

- It is important to develop interventions that create social spaces not based upon sex or alcohol or substance use.
- The impacts of dating apps in the Spanish context and health are under-researched and required a thorough interdisciplinary approach.
- The sexual transformation that has occurred necessitates new approaches to sex education that provide tools for managing pleasure.
- Chemsex presents a complex and still poorly understood issue that requires collaborations between institutions and communities.

Sexual Health and the Healthcare System

Key findings:

- The current approach to sexual health is primarily biomedical and hospital-centred, often neglecting the social, emotional and psychological aspects of sexual health.
- Healthcare is fragmented, with multiple institutions lacking coordination and resources.
- There exist deficiencies in medical training, particularly relating to socio-cultural competencies among healthcare staff.
- Stigma related to sexual health and sex is prevalent, affecting both patients and professionals.
- The establishment of a specialty in infectious diseases and the transfer of some sexual health care to primary care are both potential future avenues.

This chapter discusses the perceptions about the healthcare system expressed by the interviewees. It starts from the definition of sexual health proposed by the WHO (World Health Organization 2006). We acknowledge that it is not the only possible definition, but it serves as a shared framework and allows for a critical reflection on how health policies are being implemented in our country. Thus, it is necessary to recognize that the approach to sexual health within the Spanish healthcare system is characterized by a biomedical focus, the presence of stigma related to sex and HIV, and the relegation of non-medical professionals and community organizations to a subordinate role. Sexual health care faces numerous problems: fragmentation of the healthcare system and lack of coordination, lack of resources, training deficits, and stigma. It is also important to highlight the role of primary care as a possible entry point into the healthcare system regarding sexual health, and the role of community organizations.

Approach to Sexual Health in the Healthcare System

According to the World Health Organization, sexual health should be understood as the highest degree of physical, emotional, mental, and social well-being related to sexuality (World Health Organization 2006). Healthcare related to this sphere has focused on

promoting the use of barrier methods (such as condoms), treating STIs, and prevention (such as PrEP). In this sense, the Spanish healthcare system has adopted a predominantly biomedical approach to sexual health care, something recognized by several of the people interviewed. Specifically, some professionals highlight that the current system does not address the complexity of sexual health as a phenomenon interconnected with psychological, emotional, social, and cultural aspects. A senior civil servant comments:

> We have not the more cultural and social aspects too much. [...] So, [integrating the social and cultural component to understand the needs of patients] is something that we still lack. (P9)

The predominant biomedical approach to sexual health care in the healthcare system reflects a limited and mechanistic understanding of sexuality. As an activist points out, one of the key problems is that sexuality is not seen as an integral part of general well-being, comparable to other aspects of physical or mental health:

> Sexuality is not something that is seen naturally, it is not something that is considered as just another element of an individual's health. It is not understood that good sexual health affects people's lives and, therefore, like any other health issue, it is of public concern. (P19)

Another possible explanation is that sexuality has always been considered a social taboo and, therefore, also within the medical field. Indeed, sexuality has been a topic laden with taboos and moralism, which have hindered its full integration into the public health discourse and medical practice. This situation has been widely recognized by both users of the system and professionals who provide care for these issues. A specialist doctor explained that "the issue of STIs comes with morals and ideology, certainly from bosses, managers, and executives" (P4).

Moreover, many people face emotional challenges related to their sexual life, whether due to self-esteem issues, anxiety, or difficulties in interpersonal relationships. The biomedical approach does not address these aspects, leaving a significant part of the sexual experience and its implications for mental health unresolved. A doctor working in the community setting reflects on this: "We see many people like this, who carry unresolved emotional disorders, so to speak, that are not addressed in healthcare. But it is also true that we have many limitations in this regard, so sometimes opening this can of worms is a bit scary." (P2)

This view has conditioned that sexuality is only addressed in terms of disease or dysfunction. This leaves out the promotion of healthy sexuality, based on pleasure, consent, and sexual freedom. As a result of this reductionist approach, policies and measures often lack a holistic vision, making them ineffective and insufficient in the medium and long term, limiting their ability to generate a profound and sustainable impact on the population's sexual health and, more specifically, on the LGBTIQ+ community. In this regard, a doctor wonders:

> Are we really solving the problem at its root? There are many aspects in the LGBT world, in the queer world, in the GBMSM world, where neither a pill nor PrEP will solve the whole problem. [...] That's a band-aid on the whole problem of sexual health. I think there are other aspects that need to be addressed. (P4)

From the community perspective, which will be discussed later, the end of HIV exceptionalism and the emphasis on treatment as prevention (TasP) have deepened the view of sexuality as pathology, with the consequent relegation of community entities to a subordinate and secondary role.

Care for People Living with HIV

The care of people living with HIV in Spain largely relies on the formal healthcare system. Infectious Disease Units lead the care for these individuals, who usually have little contact with other specialties, including Primary Care. Care for other STIs has been organized around this same model. In this traditional care model for people living with HIV, the predominant approach has been biomedical, focused on the clinical management of the disease. From diagnosis to follow-up, care for these people has been based on controlling viral load and T CD4 lymphocyte counts, with the aim of preventing the development of AIDS and other associated complications. This model has focused on survival and antiretroviral treatment, given that during the early decades of the epidemic the priority was to prolong patients' lives and manage the physical consequences of the infection.

This approach has been effective in terms of prolonging the life expectancy of people living with HIV and reducing associated morbidity. However, it is also limited, as it did not adequately consider other fundamental aspects of patients' lives, such as quality of life. This model treats HIV as a chronic pathology but does not give enough importance to psychosocial and emotional factors, nor to the social integration of patients. With the discovery of the Undetectable = Untransmittable (U=U) principle, there is a need for the management of HIV infection in the healthcare system to evolve towards a more comprehensive approach. As an HIV specialist doctor interviewed points out, "a healthcare professional who only tells you how much CD4 you have and how much viral load you have [...] does not see reality because, today, viral load is not the problem" (P4). What is expected today is that HIV management is carried out by specialized medical staff who understand the social and emotional needs of PLHIV. As an activist points out,

> healthcare professionals are supposed to be sufficiently sensitized and trained, but they must have a more proactive attitude, create space for dialogue, accompaniment, and follow-up, not only on a biological level but also on a psychosocial level. (P20).

In this regard, it is worth noting that there are increasingly more HIV and STI units in hospitals, allowing healthcare professionals to specialize in this area.

Problems in the Healthcare System

Fragmentation and Lack of Coordination

Several participants agree that the sexual health care model is excessively fragmented, making it difficult to provide optimal and equitable healthcare. This fragmentation creates disparities in access to sexual health services. The lack of coordination between different actors in the healthcare system, such as STI centers, hospitals, and community organizations, prevents an integrated and efficient response. An activist commented:

> I would really like to see real coordination between centers, between STI centers, hospitals, and community organizations. It should be something more cohesive. There should be much more communication, much more coordination. Because I think if we were more coordinated, we would be much more efficient. (P8)

Other interviewees do describe examples where community organizations had "taken the initiative" to address certain problems that were not being addressed by the healthcare system, but they still point out gaps in coordination that hinder full integration. For example, speaking about chemsex, a doctor explains that

> It is a problem that we are not addressing from any perspective. Currently, Community organizations carry part of that work, and my perception is that they have taken the initiative, as almost always happens, to address it, but I think we need to coordinate between services, with addiction centers, to really provide a somewhat more effective solution. (P4)

Thus, the urgent need to redefine care processes is highlighted, better integrating the different levels of care and improving coordination between entities to offer a more effective and adapted response to the needs of these people.

Lack of Resources for Sexual Health

One of the most consistent comments in the interviews is that STIs have never received enough resources. A senior civil servant concludes that "STIs have never been a priority in public health or healthcare management. There are other health issues that take up most of the resources" (P9).

Despite STIs, particularly HIV, being public health issues that affect vulnerable sectors of the population, STIs have been sidelined compared to other pathologies that are seen as more urgent or visible:

> The impact they can have is not seen. If a cancer patient comes in with bacteremia, that is, bacteria in the blood, they are treated, mortality is reduced, and that is seen. In contrast, STIs, and even HIV, will not kill you. (P4, specialist doctor)

An activist complained that HIV and sexual health "stopped being politically interesting quite some time ago, and because of this, the political importance and public effort toward prevention is practically nonexistent" (P19). Given this context and the relationship between sexual health and stigma (as indicated earlier in this chapter), it is not surprising that there is a feeling that professionals dedicated to HIV and sexual health "are not fully valued" (P4, specialist doctor).

This is partly due to the social invisibility of sexuality and the perception that STIs are an issue limited to certain population groups. As mentioned by some of the interviewees, sexual health is not considered a fundamental pillar of universal healthcare.

A related structural barrier is the lack of funding and resources in specialized units to address STIs and HIV. Despite the increase in the incidence of these pathologies, the units dedicated to sexual health in the Spanish healthcare system have received insufficient resources, both human and material, compromising their ability to adequately respond to the growing demand. This results in underfunded sexual health units with insufficient professionals to attend to the volume of patients and inadequate infrastructure, limiting the effectiveness in prevention, diagnosis, and treatment programs. A doctor working in one of these units complains in these terms:

> We lack human resources. For example, in PrEP, we have two thousand users. Since we started with ten [users], we have the same staff, and we are overwhelmed. We have gone from doing quarterly check-ups to every four months. We can no longer check them every four months. We will move to every six months. (P4)

This underfunding context can be exacerbated by budget cuts that have deeply affected the Spanish healthcare system in recent years (Karanikolos et al. 2013; Urbanos Garrido and Puig-Junoy 2014). Budget cuts have directly impacted sexual health services, leading to staff reductions, which in turn have generated work overload for healthcare professionals, negatively affecting both patients and staff. First, the overload limits the time available for the individualized care patients require, a situation that can negatively impact access to and the quality of care. An activist explained that their biggest fear was "the loss of healthcare services. I see the resources and care declining, like the improvement or care for people with HIV in the healthcare system is starting to decay" (P18).

Second, the increased workload also means that professionals have fewer opportunities to address emotional or overall well-being aspects related to sexual health, which can compromise the holistic treatment that sexual health requires, something particularly relevant when considering the subordinate role given to non-medical professionals and community organizations. Finally, the overload severely affects healthcare professionals, who face the risk of burnout, especially after the COVID-19 pandemic (Benavides et al. 2024). This chronic stress resulting from excessive workloads, coupled with a lack of resources and institutional support, can lead to a decrease in motivation, responsiveness, and empathy towards patients, further exacerbating the healthcare system's collapse.

Training Deficits

Participants also described a lack of medical specialization in sexual health, which is a significant obstacle to effectively addressing STIs and HIV. Currently, the number of professionals specialized in sexual and reproductive health is limited, reducing the healthcare system's capacity to provide comprehensive and holistic care in this area. Training in sexual and reproductive health often depends on the will and initiative of the professionals themselves. In many cases, doctors and healthcare staff interested in this area must seek complementary training on their own, as it is not part of the formal training structure. Thus, a specialist doctor explains their training trajectory in these terms: "I have been training with this or that independently [...] between courses, master's degrees, and all, but of course, [sexual health training is] something that I have missed and that I continually seek" (P4). This leaves sexual health specialization to individual discretion, creating inequalities in the quality of care depending on the center or the staff providing it. A senior civil servant explains the following:

> When we analyzed the training needs of the different professionals (specialized care, primary care, prison institutions, community entities), they always told us they didn't have training, for example, in LGBT cultural competencies and often didn't know how to address certain issues in consultations without stigmatizing, how to understand the needs of their patients, etc. And that's a big problem, a huge barrier to providing quality healthcare, both in HIV and STIs, because if a good doctor-patient relationship isn't established, then forget about it. (P9)

In this context, the creation of the Infectious Diseases specialty has been identified as an important proposal to alleviate much of this deficit. This specialty would allow for the training of doctors with more specific and in-depth training in managing infections such as STIs and HIV, as well as in the management of preventive aspects and the comprehensive treatment of these pathologies. It would also allow for an approach to the needs and contexts of the patients. A doctor explains that,

> If there were a degree of specialty or sub specialization in sexual health, it would be a positive point. I don't think it would solve the whole problem, but I do think it would add another dimension [...] The ideal would be to have the Infectious Diseases specialty. And within that area, perhaps having a, well, a sub specialization in sexual health. (P4)

From an activist perspective, they call for the creation or utilization of multidisciplinary spaces where community knowledge is valued.

Stigma

A key point identified by many interviewees is the lack of awareness among healthcare professionals about sexual health and STIs. Patients who go to the healthcare system with concerns related to HIV or STIs often encounter limited care, not only due to a lack of

resources but also because of the limited awareness and ignorance of the professionals themselves regarding these issues. An activist mentioned that “doctors, even many HIV professionals, don’t have the necessary training to address sexual health because they are uncomfortable talking about sex” (P11).

This lack of awareness has a direct impact on the care received by people living with HIV or other STIs, who often face stigmatizing attitudes or inadequate information from healthcare staff. This is particularly problematic for LGBTIQ+ people, who already struggle with access barriers and social stigmatization. Data from the latest survey by the European Centre for Disease Prevention and Control (ECDC), published in 2024, reflects how stigma persists in the healthcare field. For example, about 15% of surveyed healthcare professionals expressed a preference to avoid providing care to MSM or transgender people. Of these, approximately half argued that the main reason for preferring not to provide care was the belief that these groups engage in immoral behavior or concerns about the perceived risk of disease transmission (European Centre for Disease Prevention and Control 2024c).

Self-stigma related to HIV also plays a fundamental role in how people interact with health services. Fear of rejection and stereotypes associated with the disease lead many people to underestimate their risk of contracting HIV, resulting in a lower predisposition to seek healthcare. This fear, in turn, fosters the concealment of the diagnosis, causing many to avoid getting tested or not attending necessary medical and social services. In this way, self-stigma acts as an invisible but persistent barrier, hindering access to HIV diagnostic, prevention, and treatment services, perpetuating the vulnerability of those most in need of care (Jeffries et al. 2021). An activist gives an example: “There is a lot of ignorance. I know a general practitioner [primary care] who lives with HIV, who has horrible internalized stigma” (P11).

The Role of Primary Care

Primary care could play a key role in sexual health care for people living with HIV or STIs. This area of medicine has the potential to offer a generalist, accessible, and close-to-the-population approach. Some regions (Comunidades Autónomas) have implemented an STI care model in which Primary Care is the access point for people concerning sexual health. An HIV specialist doctor argued that primary care was the logical healthcare setting for sexual health:

> I think STIs are not specific to an infectious disease specialty. The ones who should handle them are primary care doctors because that’s where patients go first. A gonorrhea infection can be perfectly treated by a general practitioner, who is more accessible. I’m not saying HIV, which is a chronic infection. Gonorrhea can be perfectly treated, they give you a treatment plan at the primary care clinic and a shot, and it’s more accessible. I don’t think a hospital do that. Primary care doctors are the ones who are in contact with the person, with the partner, with that world. (P14)

However, there is also talk of a lack of preparedness among primary care professionals to effectively address topics like HIV, PrEP, or post-exposure prophylaxis in cases of risky contact. An activist and researcher comments that one of the main problems is that “in primary care, not everyone talks to their doctor naturally to explain that they have sex with men or situations with drugs” (P15). This reveals a trust gap between patients and primary care professionals regarding sexual health issues, especially in vulnerable groups like GBMSM or people who use drugs.

In this sense, it is evident that a greater training effort is needed for primary care doctors to provide more sensitive, informed, and prejudice-free care, which would help reduce stigma and increase the effectiveness of care. Although primary care staff generally have a broad and generalist knowledge of various pathologies, they need specialized training to adequately handle the complexities of sexual health and HIV prevention.

On the other hand, while shifting sexual health to primary care may offer benefits, it is not the solution for everyone. An activist highlights that some populations, especially the most vulnerable, may avoid going to primary care centers for fear that their condition or identity will be discovered. These individuals might prefer to travel to other cities for care to preserve their anonymity and avoid stigma or social judgment from their social contexts (P20). This suggests that, although primary care has accessible potential, it is not suitable for everyone, particularly those who face greater risks of exclusion or stigmatization.

Finally, a doctor in the community setting notes that while STI units in hospitals may be overwhelmed, some family medicine professionals are already taking on sexual health care effectively, especially those who show interest in the area (P2). This indicates that, with proper training and the development of greater sensitivity toward sexual health, primary care can play an increasingly important role in preventing and managing HIV and STIs. However, it is recognized that for certain groups, primary care will not be the ideal space, so it is essential to maintain a diverse network of services that can adapt to the different needs and realities of the population.

The Role of Community Organizations in the Healthcare System

Community organizations play a crucial role in caring for PLHIV and in the prevention and management of STIs in Spain. Community organizations not only complement but often lead initiatives that the formal healthcare system cannot effectively cover, especially in prevention, psychosocial support, and care for vulnerable populations. These organizations are essential for providing a closer and more personalized approach, “because they are really at street level, they are with the user and know where the problems are” (P2, doctor).

One of the most relevant aspects is that Community organizations are the only actors involved in addressing chemsex. The lack of institutional intervention in this area has left Community organizations as the only ones truly facing the problem in its entirety, offering

not only information but also accompaniment, psychological support, and, in many cases, access to harm reduction services (P2, P8).

Another key aspect that Community organizations address is peer support programs for PLHIV. This support model, in which people living with HIV accompany others who have just been diagnosed or are in complex stages of the disease, has proven to be extremely effective. Peers offer a type of emotional and practical support that healthcare professionals cannot always provide, helping to reduce stigma, improve treatment adherence, and facilitate the social integration of PLHIV. This type of support, based on empathy and shared experience, is essential for improving the quality of life of affected people, and Community organizations are the main ones responsible for structuring and offering these services. An activist who coordinates a peer program explains that there are studies that show

> that with the peer program, quality of life evidently improved greatly. Because, of course, it becomes normalized, it normalizes a lot. And there is an exchange of information that is not available if you don't have peers. It is an update on information and access to knowing other people with HIV, to normalize it, to have a space to talk, to have the necessary information to know how to take care of yourself. (P18)

Finally, it is important to highlight the advocacy work that many Community organizations and local entities have carried out to defend the rights of people living with HIV and to organize joint efforts. These organizations have played an essential role in making the needs of PLHIV visible and in pushing for improvements in health policies through campaigns and spaces for dialogue with public administrations and other key actors.

A concerning aspect that is also highlighted is that the services offered by Community organizations in addressing chemsex are beginning to become overwhelmed. As Community organizations have taken on an increasingly central role in social and healthcare, especially in providing non-strictly medical services such as psychological care, peer support, and prevention programs, their resources are being stretched to the limit. These organizations, often with unstable and limited funding, face growing demand, putting at risk their ability to continue providing effective support to all who need it. A doctor working in a pioneering NGO that supports people experiencing problematic chemsex explains that

> The chemsex group is now working quite well. And it is providing fairly quick support. But we've found times when we sent people to our chemsex support and we knew [that] they wouldn't be able to take them in for another three months. Because they are completely overwhelmed. (P2)

Recommendations:

- It is urgent to develop training programmes (both formal and informal) in sexual health and the related socio-cultural competencies.
- Coordination between institutions and entities requires a systematic effort to collect data on what services are available and where.

Politics, Activism, and Institutions

Key findings:

- Participants described a growing politicization of sexual health which subjects health promotion activities to political fluctuations.
- There is a clear problem with the current funding model, which is fragmented and does not guarantee the longevity of programs or the retention of professionals.
- Community organisations exist in competition due to a lack of funding.
- There is a declining interest in HIV which has required some community organisations to evolve in their objectives.
- There is an interest in upstream policies. Community organisations can contribute to these policies with the knowledge gained in their fight against HIV.

This chapter addresses the relationships between the different entities working in the context of sexual health: government institutions (including the Ministry of Health and the devolved regional governments [Comunidades Autónomas]) and community organizations. First, we reflect on the dynamics of participation of community organizations in governance and policies related to sexual health, suggesting that the politicization of sexual health, fragmented governance, and the dependency of community organizations on scarce government funding hinder full participation. In particular, we highlight how current funding frameworks create dynamics of dependency and competition between community organizations. We also describe the changes characterizing the post-AIDS era, marked by a decreasing interest in HIV and the evolution of community organizations toward new models, requiring the imagining of new futures.

Participation

Decades ago, UNAIDS argued for the centrality of community and civil society organizations, alongside public health authorities and the health sector, in public health policies for the response to HIV. Recently, the United Nations General Assembly reiterated that successful HIV response policies must involve the participation of various social actors in "decision-making, planning, implementation, and monitoring of the HIV response," thereby ensuring

the outreach of interventions, access to the most vulnerable populations, addressing the different sensitivities involved, and ensuring the shared responsibility of all the agents involved (Joint United Nations Programme on HIV/AIDS 2024).

The concept of "participation," however, can be a term laden with ambiguity. In some cases, it is limited to the discursive or performative level and is not accompanied by mechanisms that allow for participation on equal terms in practice. In this sense, a senior civil servant explains that the current situation allows for both discursive and practical participation:

> Now, with this team, besides discourse, there is knowledge, there are budget allocations for actions, which in the end is what also matters. You need to have discourse, but you also need to put in resources. (P12)

Regarding the role of the Ministry of Health [Ministerio de Sanidad] and the bodies that, under various names, have been responsible for the response to HIV and sexual health, participants note that in recent years there have been significant advances in implementing an effective participation policy. Specifically, the reactivation of the National Commission for Coordination and Monitoring of AIDS Prevention Programs [Comisión Nacional de Coordinación y Seguimiento de Programas de Prevención de Sida], created in 1993 but only sporadically active until very recently, is mentioned. A participant, a senior political appointee from the Ministry, values the reactivation of this Commission as a fundamental piece in articulating effective civil society participation:

> In recent years, there has been great progress in making this a body of participation from which subsequent initiatives could emerge with the Ministry's seal. A bit of the initial idea: Nothing for the people who have something to say without the people who have something to say. (P10)

Obviously, this does not mean that community organizations did not voice their claims to authorities before the existence of these official participation mechanisms. Some participants describe what we might call informal participation mechanisms: "We never had [stable dialogue with the administration]... We always went looking for 'hey, I know so-and-so' or 'I know this person.' We've always operated that way" (P6, activist).

Naturally, this activist does not fail to recognize that, although informal participation can be effective, its instability and lack of transparency are evident. Something that also affects, as we will see later, the funding of community organizations' actions, a key tool in public policies related to HIV and sexual health. The funding process for community organizations is understood by some participants as a relationship of subordination, not only due to their dependence on public funding but also because it is the funding body (Ministry, Comunidades Autónomas, etc.) that decides the priorities and processes. A civil servant explains that "organizations here live off grants, and I think they don't want to stir things up. [This causes] a very weak movement" (P1, civil servant). All of this makes it so that changes in

priorities or actions related to sexual health and HIV not always respond to community interests. This civil servant explains that "there have been changes, somewhat towards what were the demands—not of communities or society, but of the administration" (P1).

The Social Pact for Non-Discrimination and Equal Treatment Associated with HIV is mentioned by government informants as an exemplary case of public policy promoting full civil society participation (Plan Nacional sobre el Sida 2018). A long-standing participant who has witnessed various local, regional (Comunidades Autónomas), and national governments also values it:

> There are governments that are more aware than others because, for example, the social pact against discrimination, which was hidden away in a drawer by one government for who knows how many terms, until another party came along and brought it out, and it's been signed. That is, there are governments that hide things in drawers and don't want to know anything about HIV. (P5)

As one participant said, the possibility of participatory governance ultimately depends on the existence of a culture of shared responsibility among the different agents. In this sense, the current Ministry's efforts may be an opportunity to generate the necessary culture for policies to be debated, negotiated, and adopted by the different agents.

Regional Government: Comunidades Autónomas

In a context like Spain, it is essential to consider the role of the regions or Comunidades Autónomas in shaping HIV-related policies, as they are the ones with delegated public health powers. There is a certain consensus among our participants that dialogue with public health bodies at the regional level (Comunidades Autónomas) depends on the political party in power. They point out that, in a context of political polarization, it has been the more progressive governments that have most favored policies and supported programs responding to HIV through grants. A senior civil servant explains this situation in relation to the implementation of PrEP

> Spain is very decentralized. All decisions, governance is shared with the Comunidades Autónomas, and the implementation of PrEP was a pain because there was a lot of tension between right- and left-wing regions against it. (P12)

At the same time, an activist highlights the importance of political affinity in establishing communication channels between community organizations and political appointees: "Here, if they meet with you, it's because they are on your political side or you are in theirs. That's the problem; there's a heavy political burden in our groups" (P6).

It's important to note that there is a difference between the political discourse of Comunidad Autónoma governments and the technical management of public health by civil servants.

So, although there may be changes in the ideology of the ruling government, there is a certain continuity at the technical level. A senior civil servant explained, talking about a conservative-led Comunidad Autónoma, that "in [this Comunidad Autónoma], the political discourse is negative, although, in reality, there is a reasonable technical level and widespread acceptance at the societal level of sexual diversity" (P12).

For most community organizations, their main source of funding comes from their regional government (Comunidades Autónomas), as local or regional programs do not access the Ministry's grant program. It should also be noted that not all Comunidades Autónomas or, certainly, municipalities have community entities with experience in responding to HIV, and these entities also have very unequal presence and trajectories. An activist explains that "there are many territorial differences, in rural areas and between regions" (P20).

Funding and Fragmentation of the Community Model

As mentioned earlier, grants to community entities are one of the most powerful tools that government entities have to define a political agenda and to structure their relationships with community organizations. In this sense, all the interviewees consider the funding from public institutions to be insufficient.

> The funding is] terrible. Why? Because public administrations have budgets, if they exist, because in some places they don't exist. If they do exist, they are meager. If it weren't for pharmaceutical companies, international grants, foundations, and in some cases co-payments, it would be unsustainable… The funding is ridiculous. (P5, activist)

Despite the importance of their work, Community organizations face significant barriers, especially concerning funding. Financial instability is a recurring complaint. The participants point out that Community organizations often depend on fixed-term grants, which makes medium- or long-term planning difficult and leaves them vulnerable to political or bureaucratic shifts. This financial uncertainty hinders the continuity of projects and puts staff employment at risk, making it hard for Community organizations to operate consistently and with the necessary stability to run effective programs. An activist who runs an HIV NGO explains:

> The grant from the city council is the largest part of our funding. If they tell us there's no money, we have to think about who we will lay off. But the programs are running, so we can't lay anyone off. (P11)

In turn, this creates a lack of professionalization in the community sector: "I miss professional [activist] figures who are very clear about this, but it's difficult to make a living from it" (P1, civil servant).

Some of the activists interviewed suggest that this lack of adequate funding creates a climate of competition and mistrust among community organizations: "There are competitive relationships, and there are certain perspectives that I find a bit alarming" (P20, activist). This person goes on to suggest that the administrations intentionally create these context:

> I think the administrations use this—they love to see us divided, and they love that we compete with each other. And that, to me, is very sad... For example, there is a deliberate policy of giving small amounts of money to 18 organizations doing the same thing so that they have no choice but to compete with each other. (P20, activist)

Along with funding, the second issue highlighted by the informants—whether they are from government, the health sector, or community organizations—is the lack of equitable collaboration among the various agents. The absence of collaboration leads to everyday problems: the lack of coordination of groups addressing the same issue from different institutions, duplication, and missed opportunities for referral between institutions are among the most commonly mentioned. For example, a specialist doctor argues:

> I would like to have a more collaborative relationship with other Community organizations and doctors: I have this, what do you need as a hospital? How can I help you? Hey, when do you need me? (P4).

However, at the same time, they are aware that there are barriers to this type of collaboration:

> But of course, I also think, Community organizations are also fighting to maintain their position, their money, their funding, it's normal. So I often feel like all interests aren't being protected, and it's hard to figure out how they all come together. (P4, doctor)

In other words, in the context of competition and fragmentation, the needs of the users and patients can sometimes be overlooked.

These changes have been gradual, and it is the activists with the longest experience who describe a sense of change:

> Now, we don't have that feeling of community that we used to have. We've been creating our own niches of care. So, while we may have a very good relationship with several community organizations, we don't have that sense of community that we had 20 years ago. (P8, activist)

Relevance and Interest in HIV: The Post-AIDS Era

As a social problem, it is arguable that HIV has lost media relevance since the mid-1990s, thanks to the decline in HIV-related mortality brought by highly effective treatments and a certain perception of the containment of the epidemic's progression in the most vulnerable

groups (Villaamil Pérez 2004). Adding to this, the potential disappearance of HIV as a public health issue becomes more plausible due to treatment as prevention (TasP) and PrEP (Parker and Aggleton 2023). This has had a decisive and transformative impact on public health policies, deepening what has been described since the late 1990s as the end of AIDS exceptionalism or the post-AIDS era (Kagan 2018). For some participants, this impact has resulted in the relegation of HIV prevention, particularly regarding the defense of sexual rights:

> My personal opinion is that [HIV and sexual health] has not been politically interesting for quite some time. Because of this: political importance and public efforts towards prevention are practically nil. (P19, activist)

Community organizations have found themselves needing to redefine their identity in this new context. An activist comments:

> We're at a point where HIV is no longer on political agendas and is not a priority. Even we, the organizations, have already shifted a bit. Once you have people on medication, the great urgency of HIV has passed. (P6)

There is diversity in how the new situation is understood and its opportunities and risks. For some participants, advances in treatment and prevention are successes that should be leveraged and celebrated. For others, however, they represent an existential challenge: the absence of the sense of urgency that characterized the first decades of HIV signifies the dismantling of HIV exceptionalism. This refers to the development of innovative approaches that were comprehensive, incorporating a rights-based perspective and a concept of health as a multidimensional phenomenon. Thus, one activist laments that the evolution has been toward a context in which HIV prevention revolves excessively around pharmaceuticals, overlooking other issues. As we mentioned earlier, an activist complained:

> When we talk about combined prevention, we've stuck to the medical part. But what about all the structural changes that need to happen for people to live better? Where do I talk about poverty? That's combined prevention too! (P21)

This new context requires re-imagining the role of community organizations. From the interviews, two alternatives emerge. On the one hand, there is the possibility of becoming community organizations focused on providing services to the LGBTIQ+ community that, due to their "capillarity," reach where healthcare does not, but are not specifically centered on HIV. Thus, an activist explained that their organization focuses on providing high-quality healthcare services by specialized healthcare personnel for the LGBTIQ+ community, justifying it by saying: "These services are already an acquired right of the community; we cannot do without services like ours because the healthcare system cannot absorb all this demand." (P7)

On the other hand, we find other organizations—generally from the associative fabric that took shape in the first decades of the HIV response—that redefine their mission in terms of fighting for sexual and reproductive health rights, but also in a conception of health that integrates economic, social, political, and existential dimensions. One of these activists explicitly rejects a healthcare service delivery model:

> For me, that [healthcare service delivery] route isn't the right one. It's not the route I think is appropriate because it's just about depending [on political and healthcare institutions]; it's about becoming part of them. There's another route, the route of rights. (P20)

This second route, focused on rights, is linked to different ways of organizing activities. Thus, the same activist argues that community organizations require democratic mechanisms that allow permeability between users and activists or managers, ensuring rootedness in the community. This means, for example,

> that sex workers can reach the Board of Directors and make decisions as sex workers. If those pathways and democratic channels don't exist, I don't see that entity as a community entity. It could be an agency, an community organization, but not a community entity because it functions more like a company than a community entity. (P20)

It is important to note, however, that talking about these two alternatives is more of an analytical matter than a practical one: most community organizations participate, to a greater or lesser extent, in both service provision and the defense of rights. For other activists, regardless of these two options, the emphasis should be on maintaining the positive aspects of previous contexts, such as collective learning:

> All that learning from community work, the promotion of sexual health, and the promotion of sexual health from a community perspective, from the 80s, from the learning of how communities can exercise that right. It must include an integrated view of health care, of what we understand by health, structural changes, etc. (P21, activist)

In this sense, it is worth highlighting that there is a certain agreement among the senior political and civil servants interviewed on the need to maintain a balance between horizontal policies (structural changes that promote health improvements for the general population and, therefore, also for specific populations) and vertical policies (interventions that selectively affect the living conditions of specific communities). Thus, a senior political appointee advocates for:

> the recovery of universal health coverage, the improvement of primary care services: these are measures that act horizontally and will improve the situation of STIs in the same way that they will improve the treatment of cancer or ischemic heart disease. (P10)

On the other hand, this same political appointee refers to the need for an understanding of health from the perspective of the social sciences as a social and political process, with both

objective dimensions (who gets sick and how) and dimensions of meaning (what sense-making mobilizations are taking place when we classify a phenomenon as healthy or as a disease) (Fassin and Gomme 2023). Thus, they argue that, from a broad and complex concept of health and illness, the response to HIV requires:

> not only addressing the final consequences of treatment but also the social determinants that drive its emergence. We need to act not just downstream but upstream as well. (P10, senior political appointee)

Futures

A question that remains unanswered is what strategies arise from the post-HIV exceptionalism scenario. In this phase of the epidemic, many of the issues that affect the most vulnerable groups regarding HIV—such as the ageing population with HIV, the inclusion of migrants, or the violence affecting trans people—are no longer understood as problems affecting a specific group or requiring interventions aimed at specific populations. The demand for a fairer pension system or a more inclusive immigration policy entails interventions in debates that go beyond the specificity of HIV and sexual health, although they decisively affect certain populations, such as recent debates around the gender identity of the trans community. Participants are well aware that these debates currently have a highly volatile nature in a context of strong polarization and the emergence of far-right positions that have taken these issues as rallying points for their electorate.

Recommendations:

- Consolidate participation pathways that depoliticize sexual health.
- Modify the current funding model to ensure the continuity of programmes and the retention of professionals.
- Encourage collaboration among community organisations, promoting the sharing of talent and professional skills.
- Collect, value, and mobilize the knowledge gained in the fight against HIV to address other health issues.

Society, Culture and Education

Key findings:

- The current context is marked by a “second silence,” which implies the invisibility of HIV and sexual health.
- There are suggestions of there being an “identity crisis” underlying phenomena such as chemsex. This crisis is characterized by loneliness and a lack of leisure activities.
- Art, literature, dance and theatre serve as engines of social change and can provide essential tools to address sexual health but require new funding models which allow for long-term cultural interventions.
- There are significant deficiencies in sex education, partly due to its politicization.

This chapter addresses the issue of sexual health in the context of society, culture, and education. First, it describes the current situation as a "second silence" marked by the individualization and invisibility of HIV/AIDS and sexual health, which complicates community discourse and approaches to this reality. It also describes what several participants have identified as an "identity crisis" affecting the GBMSM (gay, bisexual, and men who have sex with men) community in Spain—a crisis underlying phenomena such as chemsex. Building on the reflections offered by the participants regarding the sociocultural dimension intertwined with sexual health, the chapter calls for the creation of multidisciplinary spaces where we can address this phenomena in all its biomedical, cultural, and social complexity and diversity. Specifically, this chapter describes the importance of culture as a driver of change and discourse creation in HIV/AIDS and sexual health, and highlights the urgent need to adopt new perspectives to approach sex education in Spain.

The Second Silence

In 1986, the U.S. group "The Silence=Death Project" popularized one of the central slogans of HIV/AIDS and sexual health activism, "Silence=Death." As Avram Finkelstein notes, the slogan aimed to allude to "the lethal effects of passivity in the face of the crisis, the collective silence and the political nature of that silence, silence as complicity" [“los efectos letales de la pasividad ante la crisis, al silencio colectivo y a la naturaleza política de ese silencio, al

silencio como complicidad”] (in Galaxina 2022, 73). The relevance of this anecdote lies in the parallels the participants draw in the interviews between the context of silence in the 1980s and 1990s, and the present, when collective silence also reigns around HIV/AIDS and sexual health. One participant explains the following: "There was a first silence, right? With fear and people dying, and nobody knew anything, there was panic, and it wasn’t talked about. That was the first silence of the 1980s and 1990s. Now there is a second silence" (P17, artist).

The idea of the "second silence" mentioned by the participant has been noted by several authors and is linked to issues mentioned in previous chapters. Given modern treatments and, especially, the rise of non-transmissibility expressed in slogans like Undetectable=Untransmittable, we are currently living in a context where the reality of HIV/AIDS and, in general, sexual health has begun to become invisible. This same participant frames the situation in these terms: "Now I take my little pill, I look good, I’m fabulous, I don’t have to tell anyone. Why would I tell anyone? Why would I talk about this? There’s a generation growing up without even knowing what HIV is" (P17, artist). Dion Kagan made a similar claim in his analysis of the concept of "post-crisis," which he used to refer to the widespread perception that today we do not live in a sexual health crisis—a perception that, according to the author, has led to a new silencing (Kagan 2018).

According to the participants, this new silence, rather than stemming from de-stigmatization or normalization of HIV/AIDS and sexual health, seems intertwined with the perpetuation of prejudices already ingrained in the social fabric. In the words of one activist:

> The fear still exists. Just because I can’t infect you doesn’t mean that fear disappears, that discrimination disappears because the components are the factors that make you be discriminated against, and they have less to do with HIV than with the fact that you’re seen as a degenerate. The social factors and prejudices are still there [...] There’s a very biomedical discourse that says this is just like diabetes. And then you scratch beneath the surface and realize that all of us have suffered some form of discrimination in some aspect. (P20)

This issue, noted by P8, P9, P17, and P19 among others, seems to be confirmed by the results of the latest report on the experience of stigma among PLHIV (People Living with HIV) in Spain (Fuster-Ruiz de Apodaca et al. 2024). During the decades following the arrival of HIV/AIDS, Spain bore witness to a gradual process of stigmatization that conceptualized the epidemic as little more than a "plague that seemed to have fallen from the sky [...] as a macabre form of punishment" (Cortés 1993, 170). It is evident, in light of the testimonies collected and the data gathered, that stigma continues to be a central issue in sexual health.

It should be noted here that this stigma and the context of silence it has produced not only originate from the institutional, media, and health spheres. Participants suggest the presence of internalized stigma among both PLHIV and people affected by STIs, with both groups manifesting feelings of guilt and shame. A senior civil servant offers a revealing comment in this regard when, analyzing the STI diagnosis process, they point out that “people really value being able to take genital samples for STIs in the privacy of their homes" (P9). The

increase in manifestations of self-stigma, evident in the search not only for privacy but also for concealment of diagnosis and treatment, is precisely one of the aspects detected in the latest report on HIV stigma in Spain:

> PLHIV in Spain reported high levels of internalized stigma [...] The majority of PLHIV reported that they find it difficult to tell people they have HIV and that they hide their serological status from others in some way. Likewise, almost two out of three PLHIV indicated that they worry about the possibility of transmitting HIV to others, and a significant portion agreed, to some degree, with feeling ashamed, guilty, inferior, or dirty for having HIV. Considering the items together, 95.0% of PLHIV experienced, to some extent, some belief of internalized stigma. (Fuster-Ruiz de Apodaca et al. 2024, 23)
>
> [Las PVIH en España reportaron unos altos niveles de internalización del estigma [...] La mayoría de las PVIH reportó que les resulta difícil contarle a la gente que tienen el VIH y que esconden su condición serológica al resto de personas de alguna forma. Asimismo, casi dos de cada tres PVIH indicaron que les angustia la posibilidad de transmitir el VIH a otras personas, y una fracción importante estuvo un poco, bastante o totalmente de acuerdo con sentirse avergonzada, culpable, inferior o sucia por tener el VIH. Considerando los ítems en conjunto, un 95,0% de las PVIH tuvo, en mayor o menor medida, alguna creencia de estigma internalizado].

In this context, participants call for greater discursive attention to the treatment and experience of HIV/AIDS and STIs, namely, a "re-signification of the imaginaries" (P17, artist). Faced with the context of rejection and "total trivialization" that, in their view, surrounds the field of sexual health today, emphasis is placed on the collective need to "create community spaces to be able to think" and also to "engage in self-criticism" (P8, activist).

The Identity Crisis

Regarding this last point, one participant makes an observation that deserves special attention when they state the following: "I think we're increasingly losing depth of discourse, of understanding the deeper and more cultural causes of all the problems surrounding HIV and sexual health" (P1, senior civil servant). The statements of other participants coincide on the need for deeper reflection on the underlying causes of the rise in STIs and phenomena such as chemsex in Spain: "In the end, there's an underlying problem that isn't necessarily about drugs, but about consciousness, identity, sociability, self-esteem" (P19, activist).

The idea that deeper exploration of the causes of phenomena like chemsex is necessary is particularly interesting in light of the importance participants place on a phenomenon they consistently refer to as an "identity crisis." According to P1, P4, P5, P18, P19, and P20, this crisis affects, specifically, the GBMSM community and, in their opinion, stands as one of the most relevant underlying factors for the phenomena explored in this report. The following statement offers a good starting point to address this issue:

> The gay community has a pretty big identity crisis, and within it, there's the sexual identity crisis or the crisis of how we behave sexually [...] It's no small thing that we're living in a time of crisis, not just sexual, and maybe sexuality is what you can see, it's like (so to speak) the manifestation. Sexuality and this increase in STIs [are] the manifestation of that deeper crisis. (P5, activist)

First, it should be clarified that this report merely reflects the impressions gathered in the interviews conducted without providing an analysis or assessment of them. It is beyond the scope of this document to affirm the presence of an identity crisis among GBMSM in Spain that could serve as a contributing factor to issues related to HIV/AIDS and sexual health. Without that analysis and the data it could provide, such an assertion could foster stigma not only against GBMSM but also, by extension, against the LGBTIQ+ community, which is why this report explicitly and deliberately avoids confirming or denying its validity. Having clarified this point, it must be noted that the participants as a whole emphasize the connection between the highlighted phenomena at hand and a deeper sociocultural issue among the GBMSM community, arising from the symbiosis of a broad set of precipitating factors. Regarding the phenomenon of chemsex, in particular, they assert that, in most cases where problematic consumption can be discussed, it stems from a conjunction of elements that exclusively affect the GBMSM community:

> Recreational drug use in our community is very visible [...] Chemsex is very visible, and what we're seeing is that [it arises] perhaps due to a lack of information, perhaps also due to childhood wounds. That is, a large part of the profile we serve with problematic drug use has many commonalities: childhood abuse, violence in their own home, in their own family, obviously bullying [...] Certain wounds that lead them to confront and manage them through substances. And also, there's the potential that 'I've always been an outcast. I've never fit in. Suddenly, I'm in a space where I feel part of something. I'm part of a community.' (P8, activist)

The fact that drug use is higher within the GBMSM community, for the reasons mentioned by the participants, has been demonstrated in numerous previous studies. Gabriel J. Martín analyzes a set of epidemiological incidence studies regarding drug use among people in the LGBTIQ+ community and concludes that, indeed, "LGBT people use more drugs to cope with the effects of a stigma that heterosexuals don't have to overcome" ["las personas LGBT consumen más drogas para afrontar los efectos de un estigma al que los heterosexuales no tienen que sobreponerse"] (Martín 2016, 155). This issue aligns with the results of the latest reports published regarding the increase in drug use and addiction among GBMSM, both phenomena linked to stigma and abuse suffered by this community (Fagúndez, Soriano, and SIDA 2019; STOP SIDA et al. 2021; Fernández-Dávila 2019).

Another recurring point regarding the connection between this community and the incidence of STIs during the interviews has to do with what several participants present as an increasing atomization and individualization of the community, as well as a persistent sense of loneliness and isolation:

> The feeling of loneliness that many people in the community experience leads them to connect with others through drugs. But what you're really looking for is connection, in the end, it's about not feeling alone [...] And that draws you into recreational drug use, to feel like you're part of a group. (P18, activist)

The emotional vulnerability of the community would be underpinned, according to the participants, by the absence of spaces for connection and interaction aimed at this audience beyond nightlife:

> It has to do with how we gays relate to each other and the few spaces we have to talk about what's happening to us. As soon as you offer safe spaces where they can talk, share, and connect, they fill up. These are spaces to escape loneliness. There's a need for non-sexualized spaces, to create networks [...] The current gay experience is much more atomized, it's much more individual, more solitary. (P20, activist)

Once again, it must be clarified that this report does not intend to make value judgments based on the recreationalization of sexual experience, nightlife, or, by extension, the existence of spaces intended for these purposes. However, the participants do emphasize that there is a limitation of meeting spaces and that this, ultimately, would act as a precipitating factor for the underlying issue behind the phenomena at hand.

Towards a Multidisciplinary Approach: Culture as a Driver of Change

Since the participants believe that these phenomena not only have a biomedical dimension but also possess a markedly cultural and social aspect, they consistently argue that the response to them cannot be exclusively provided by the health sciences. To address the realities related to HIV/AIDS and sexual health in Spain, one participant reminds us, "you have to understand and have cultural competence." This same participant, referring to the "clandestinity" that has marked the relationships of GBMSM in Spain, explains the following:

> Chemsex is a phenomenon among MSM, trans women, or non-binary people, in gay casual sex culture [...] But what is gay culture? [...] There are certain practices we do that maybe straight people don't, or they don't have them as ingrained in their imagination. (P8, activist)

Establishing spaces and resources that may enable the development of cultural competences to understand and address the needs of a stigmatized population becomes a recurring call during the interviews: participants insist on moving away from the dominance of the biomedical approach and adopting a multidisciplinary perspective (P1, P4, P5, P8, P11, P16, P17, P18, and P19). Specifically, one participant criticizes that, although the health sciences offer a necessary approach to diagnosis, prevention, and treatment, it cannot solve long-term sexual health problems:

> What's happening in our community? A lot. What's happening? A thousand things come to mind. DoxyPEP comes to mind: fantastic, I think it's great, it's been proven [effective]. Is that going to solve the problem? Yes, very good, it will solve the issue of STIs, it will reduce STIs. Are we really solving the problem? At the root, I mean. There are many aspects in the LGBT world, in the queer world, in the world of gay men, bisexuals, and other men who have sex with men, where I don't think just a pill or PrEP will solve everything. (P4, HIV specialist doctor)

If it is accepted that the reality of HIV/AIDS and sexual health in Spain has a cultural dimension, it seems logical that it should be addressed through culture. Throughout the interviews, the transformative value of this field and its importance in addressing phenomena like those explored here is often emphasized (P4, P16, P17, P18, and P19). In the words of one participant, "Social transformation, obviously, is culture. Culture at all levels. Culture [...] has an important responsibility and a great capacity to question precisely these issues" (P19, activist).

Although they point out that culture tends to be understood in Spain as a form of entertainment, questioning the prevalence of what they call "fast food culture, that is, consumed quickly and leaving nothing to reflect on" (P16, artist), the participants advocate for a reconsideration of the importance of this field, especially art, literature, dance, and theater, as "ways of creating knowledge about the world, subverting it, and deconstructing it" (P17, artist). Rather than serving as a complement to biomedical work, the participants insist on understanding this field as a productive source of discourses (and counter-discourses) concerning HIV/AIDS and sexual health, referring to the results of work carried out by local collectives such as +Art in Seville. One of the participants explains the following in this regard:

> I think it's a way to highlight problems and also highlight resources because, like it or not, it's a different way of reaching an audience [...] in a different way [...] You put on the exhibition, you reach the media; the media picks up on the exhibition; an activity related to all this is already being publicized; there are interviews, there's this, there's that... It's not just the exhibition but everything the exhibition generates. (P18, activist)

This observation, namely, that culture offers a privileged platform for dissemination, visibility, and awareness, is accompanied in all cases, however, by a complaint: the scarcity of resources and funding available to this field to carry out its work. Compared to the U.S., where art, literature, and theater addressing HIV/AIDS and sexual health enjoy a strong presence, Spain is described as a country marked by a certain artistic dispersion, stemming from the difficulties in finding support to depict a stigmatized reality: "T]here's no reflection on this because it's really hard to then find an economic outlet for it" (P16, artist). In 1997, analyzing how HIV/AIDS and sexual health were treated in Spanish art, Juan Vicente Aliaga already described Spain as "a land of silence," that is, a country lacking spaces and committed artists: "Spanish art that takes AIDS as its central theme is as scattered and diffuse as the political and social responses that have been made" (Aliaga 1997, 405).

Almost thirty years later, the participants make similar statements, underlining not a lack of interest from the arts, literature, dance, or theater, but rather what they see as an economic blockade, both from the public and private sectors. In this vein, one participant argues the following:

> It's hard to finance exhibitions [...] It's hard to find regularity [...] Until you have money to rely on, you can't carry out a project [...] Even though we meet and think about what we can do differently, we depend on an influx of money to do something [...] Sometimes we're very limited (P18, activist).

The idea that the field of culture needs more funding to address HIV/AIDS and sexual health is accompanied by another observation: "It's not just about increasing the money, which is very important, it's really about how that money is used" (P16, artist).

In addition to a clear lack of funding, the participants insist on the need to create spaces and resources that facilitate artistic creation related to HIV/AIDS and sexual health. One participant, in particular, refers to the need for "a long-term project to transform the world of culture and public consumption" and explains that funding, while necessary, should not focus solely on supporting individual artists but on generating long-term contexts for creation and exchange:

> I think institutions should promote a different kind of art, a different kind of culture [...] I would love to see a true connection between art, culture, and social justice [...] always going hand in hand. I wish there was a place to talk about this [HIV/AIDS and sexual health] [...] For me, money should never go directly to artists but, rather, to creating bold and powerful cultural policies that make the world better [...] It's more important to create the context in which this type of art can exist and make it sustainable. (P16, artist)

Sex Education

According to the participants, these cultural proposals should also be promoted through another tool: the commitment to broader (and better) education on sexual health at all levels. The participants criticize what they see as a context of censorship in the school environment, in their opinion, driven by students' families, whose rejection of sex education for young people seems inconsistent with the earlier onset of sexual activity, which recent reports place at around 14.31 years of age (with 10.3% of young people engaging in their first sexual encounters at 13 years or younger) (Moreno et al. 2020; Lameiras Fernández, Rodríguez Castro, and Martínez Román 2023). One participant summarized the issue this way:

> We should start [talking] to them, about sex education, but that's not going to happen in this country, it's not possible, because that would be all-out war in schools over what you can and can't talk about [...] Sure, if kids are starting sexual relationships earlier [...], when should we start talking to them? (P11)

A similar criticism is made by other participants (P8, P11, P17, P19, and P20), who not only assert that "there is very little sex education in this country" (P8, activist) but also that, in their opinion, access to this information is primarily mediated through pornography consumption. One activist argues in this regard that “the sex education we received, the LGBT community, is generally through porn" (P8). Along the same lines, another activist comments that “the only sex education [young people] are constantly receiving is pornography" (P19). Considering that the latest data suggest an increase in pornography consumption among the youth population, these testimonies are particularly relevant (Sanjuán 2020).

In the participants' words, "we need to start talking again, we need to develop sex education from a place of naturalness, from care, because caring for oneself is collective care" (P17, artist). The need to be responsible for the information on sexual health provided and make it accessible to the population (young or otherwise) is also pointed out by other participants, with this call to action summarized in this statement: "What information do we collect? What information don’t we collect? How do we filter it? Where do we find it? [...] I think that’s where we, the community organizations, have a challenge in verifying the information" (P20, activist).

Towards the Future

If this chapter began with the slogan of the "The Silence=Death Project," it is fitting to conclude it with a reflection made by Lee Edelman regarding the same: “If we claim that Silence=Death, then a corollary of this theorem [...] must be Speech=Defense" (Edelman 1989, 292). All the statements made by the participants seem to agree, to a greater or lesser extent, on the need to re-signify the discourses generated around HIV/AIDS and sexual health in Spain, creating intervention areas, spaces for debate, and resources to enable a cultural transformation that impacts the management of phenomena like chemsex and the rise of STIs in our territory. In general terms, their proposal involves a reconceptualization of the realities surrounding sexual health and, by extension, the mechanisms that must be implemented to address them, rejecting the dominance and exclusivity of the biomedical approach and advocating for greater intersectionality and interdisciplinarity, integrating the fields of culture, the social sciences, and the humanities, as well as art, literature, dance, and theater into the approach to these realities.

Recommendations:

- It is urgent to develop new models of interdisciplinary collaboration in all areas, from research to political participation and artistic creation.
- There is a need to analyse the possible existence of an "identity crisis" within GBMSM communities as one of the underlying causes leading to the increases in STIs and chemsex.
- It is necessary to promote the generation of discourses on HIV and sexual health through establishing spaces for artistic, literary, and performative intervention and creation.
- Social consensus must be fostered regarding the need for high-quality sex education, focused on individual and collective care and wellbeing.

Research priorities

One of the objectives of this report is to establish which lines of research are priorities in sexual health and HIV in Spain. In this regard, many participants argue that while Spain has an abundance of high-quality biomedical research, there is a significant lack of research in the social or cultural domains. With few exceptions, such as the work of María José Fuster at SEISIDA, participants comment that much of "what we know about the LGBTI population comes from other countries, not from Spain" (P1, civil servant), which creates gaps.

Participants express concerns about the lack of research on the Spanish context and demand more multidisciplinary and collaborative research. The need for multidisciplinarity has already been explored in previous chapters, but it is worth highlighting, as a civil servant argues:

> Generating data for the sake of data doesn't serve much more than designing a campaign or answering a parliamentary question. What really helps to bring about change is to engage in the social and cultural reflection. (P1)

Similarly, all those interviewed call for research to be collaborative. In particular, many participants complain that their organizations are often asked to assist in data collection for projects in which they had no opportunity to contribute to the design, which causes tension and disengagement: "Sometimes the Ministry or other entities tell us, 'we're going to participate in a study, gather the data for me, and then I'll analyze it.' But gathering that data takes time we don't have." (P2, community health doctor).
For these reasons, we believe it is necessary to reformulate funding mechanisms to ensure that research projects are designed in collaboration with communities, promote multidisciplinarity, and allow the social sciences and humanities to compete for funding.

Future Research

As part of the interviews, all participants were asked to suggest which lines of research or specific questions they would like to see investigated. Although the responses were numerous and varied, we present some of the most prominent here.

On one hand, there is a clear interest in exploring the causes and motivations underlying sexual health phenomena, including the increase in STIs, chemsex, or loneliness. In this sense, many participants suggest investigating the "causes of the causes," that is, locating dynamics such as stigma, loneliness, or the trivialization of sex within their social, cultural, material, and political contexts as a first step toward finding solutions.

Chemsex and the identity crisis emerge as two areas of particular interest. On one hand, many participants call for studies to rigorously measure and characterize the phenomenon of chemsex, as this is the necessary basis for any informed debate on possible interventions. Likewise, others suggest that it is necessary to study the motivations, experiences, and contexts of chemsex to identify the particularities of the situation in Spain. On the other hand, the need to approach the supposed "identity crisis" affecting GBMSM, particularly migrants, is also highlighted in order to better understand the problems they experience related to loneliness or, again, chemsex. In this regard, several participants stress the need to consider the material and political contexts (commercialization of gay socialization, dating apps, etc.) and their effects.

The quality of life of PLHIV (people living with HIV) is another of the most requested lines of research, both generally (in relation to the impacts of stigma and discrimination) and specifically in the context of people ageing with HIV, as well as their specific social and healthcare needs. In this same vein, other participants suggest investigating the effects of healthcare cuts on the health and quality of life of PLHIV.

Another line of research is related to understanding how young people are introduced to sexual cultures and how they acquire their knowledge, with the aim of developing better sex education resources.

A recurring request among participants is the urgent need to promote the establishment of new areas for generating discourse and to establish mechanisms that encourage debate and reflection in our society. Specifically, attention is drawn to the need to reconsider the fields of culture, art, literature, dance, and theater not as complements but as agents in the intervention regarding HIV/AIDS and sexual health. Greater creative productivity is therefore encouraged, for which it is necessary to foster spaces for engagement and creation.

Finally, applied research is also requested to develop and evaluate specific interventions aimed at facilitating access to sexual health services for vulnerable populations, particularly trans people and sex workers.

Key research priorities:

- What are the underlying causes and motivations for phenomena and trends in sexual health, notably the increase in STIs and chemsex?
- Conducting rigorous and interdisciplinary research that assesses and characterizes the phenomena of chemsex. What are the motivations, experiences, and contexts of chemsex in Spain?
- Investigate the “causes of the causes” of sexual health in Spain, including stigma, loneliness, and the trivialization of sex within its social, cultural, material, and political context.
- What is the "identity crisis" affecting GBMSM, particularly migrants, in relation to loneliness, STIs, and chemsex?
- How do material and political contexts influence the sexual health experiences of various groups and their effects (such as the commercialization of sociability and dating apps)?
- Develop and evaluate specific interventions to facilitate access to sexual health services for vulnerable populations (trans individuals and sex workers), focusing on shared and co-produced approaches.
- Explore the quality of life of people living with HIV, both in general and in the context of ageing with HIV, and their corresponding social and socio-health needs.
- How can we measure the quality of life of people living with HIV? What effects do healthcare cuts have on their health and quality of life?
- What is the impact of the implementation of universal access to healthcare laws and other bureaucratic and legislative measures on sexual health experiences and epidemiology?
- How do young people engage with sexual cultures and acquire sexual health and sexuality knowledge? How can sex education be improved?

Acronyms

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
GBMSM	Gay, bisexual, and other men who have sex with men
WHO	World Health Organization
PrEP	Pre-Exposure Prophylaxis for HIV
PLHIV	People Living with HIV
STI	Sexually Transmitted Infection
TasP	Treatment as prevention

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