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Sexualised Drug Use and Chemsex: A Hidden Public Health Challenge in Sri Lanka

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ABSTRACT

Sexualised drug use (SDU) refers to the intentional consumption of psychoactive substances before or during sexual activity to enhance sexual experience, reduce inhibitions, or prolong sexual encounters. While extensively documented among men who have sex with men (MSM) in high-income countries, chemsex remains under-recognised and poorly documented in low- and middle-income countries (LMICs), including Sri Lanka. This editorial article provides a narrative overview of SDU and chemsex, synthesising global and regional evidence on associated human immunodeficiency virus (HIV) and sexually transmitted infection (STI) risks, and situating the issue within the Sri Lankan context. Sri Lanka's youth are at a higher risk of HIV, with MSM disproportionately affected, alongside emerging patterns of synthetic drug use among young adults in urban and nightlife settings. The conjunction of substance use, sexual risk behaviour, stigma, and limited surveillance contributes to a largely hidden public health burden. A brief case illustration of two young men presenting for counselling and STI screening following exposure to a sexualised drug-use environment highlights how chemsex-related contexts can act as an entry point to high-risk sexual behaviour among previously inexperienced individuals. The editorial discusses why chemsex matters for public health, identifies vulnerable populations, and outlines prevention and response strategies, including harm reduction, integration into HIV/STI services, and community-based interventions. Recognising and addressing chemsex is timely and essential for strengthening HIV and STI prevention efforts in Sri Lanka.

Keywords: *Chemsex, SDU, MSM, Sri Lanka*

INTRODUCTION

Sexualized drug use (SDU) refers to the consumption of drugs to enhance sexual experiences, while chemsex represents a distinct SDU subculture, characterised by the use of specific substances among men who have sex with men (MSM) [1]. SDU describes the intentional use of psychoactive substances before or during sexual activity to enhance sexual experience, prolong intimacy, reduce inhibitions, or facilitate specific sexual practices. SDU has been linked with sexual and mental health outcomes, particularly among MSM [1, 2]. While chemsex is most commonly associated with men who have sex with men (MSM), it can also occur among heterosexual

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individuals. Evidence shows that the practice has expanded beyond its original subculture and is increasingly reported in heterosexual and broader lesbian, gay, bisexual, and transgender plus (LGBT+) communities [3].

Substances commonly associated with SDU and chemsex include methamphetamine, mephedrone, gamma-hydroxybutyrate/gamma-butyrolactone (GHB/GBL), cocaine, ketamine, amyl nitrites (poppers), and erectile dysfunction medications, with other substances like 3,4 - methylenedioxymethamphetamine (MDMA/ecstasy) and cannabis used less frequently [4-6]. Although initially described among MSM in high-income settings, chemsex has increasingly been recognised as a global phenomenon, including in low- and middle-income countries (LMICs) [4]. In Sri Lanka, the burden of chemsex remains largely hidden due to stigma, criminalisation of drug use and same-sex sexual behaviour, and limited surveillance data.

Global and Regional Context

International evidence indicates that chemsex is associated with a higher prevalence of HIV and other sexually transmitted infections (STIs), including syphilis, gonorrhoea, chlamydia, and hepatitis B and C [7-9]. Studies from Europe and Australia have shown that MSM engaging in chemsex report higher rates of condomless anal intercourse, multiple sexual partners, group sex, and transactional sex, alongside increased risk of substance dependence, mental health disorders, and sexual violence [10-12]. The intersection of substance uses and sexual risk behaviours amplifies HIV transmission, particularly in key populations already experiencing vulnerabilities.

Systematic reviews and meta-analyses of MSM in East and South Asia consistently highlight the high prevalence of SDU, with chemsex strongly linked to increased HIV risk [11, 13]. In the South Asian region, however, systematic data on chemsex remain scarce. The growing availability of synthetic drugs, expanding nightlife and nightclubs, digital dating platforms and applications, and cross-border mobility suggest that chemsex-related practices may be emerging but under-recognised, and this lack of visibility contributes to delayed policy responses and missed prevention opportunities.

Drug Use, HIV, and STI Risk in Sri Lanka

Sri Lanka reports that young people in Sri Lanka face an elevated risk of HIV infection, with the highest prevalence observed among MSM [14, 15]]. National HIV surveillance and Integrated Biological and Behavioural Surveillance (IBBS) data consistently show that MSM account for a disproportionate share of new HIV infections, despite representing a small proportion of the general population [15, 16]. While available national surveys focus on condom use, number of partners, and testing behaviours, a detailed assessment of SDU and chemsex is limited.

Available national data indicate a gradual increase in the use of synthetic illicit drugs, particularly methamphetamine and ecstasy, among young adults in urban settings [17]. Law enforcement and treatment centre data suggest that drug use patterns are evolving from traditional substances to newer psychoactive drugs, which are commonly linked to party and club environments Although SDU and chemsex are not explicitly captured in routine data systems, the combination of increasing synthetic drug use, digital sexual networking, and rising STI/ HIV cases among key populations points towards a potentially significant but hidden burden.

The Significance of SDU and Chemsex in Public Health

Chemsex is a significant public health concern as it brings together multiple overlapping risk pathways. Psychoactive substances reduce inhibitions and impair judgement, increasing the likelihood of condomless sex, prolonged sexual sessions, and high-risk sexual practices associated with mucosal trauma [10, 18, 19]. Certain drugs, particularly methamphetamine and GHB/GBL, are associated with increased sexual desire and endurance, leading to extended exposure periods and higher cumulative risk of HIV and STI acquisition [10, 20].

Beyond STI/HIV risk, SDU and chemsex are linked to adverse mental health outcomes, including anxiety, depression, psychosis, and substance dependence [4, 21]. Episodes of non-consensual sex, sexual assault, and overdose have been reported in

association with chemsex settings [18]. The secrecy surrounding these practices, driven by stigma and fear of legal repercussions, often delays care-seeking and reduces engagement with prevention and treatment services.

Vulnerable Populations

While chemsex can occur across diverse groups, evidence consistently identifies MSM as the most affected population [6, 22, 23]. Within this group, younger MSM, those newly exploring their sexual identity, individuals with limited social support, and those using digital platforms to meet partners may be particularly vulnerable [10,19]. Migrant workers, tourists, and individuals used to frequent nightlife and pop-up party venues may also be at increased risk. According to the available literature, factors such as criminalisation of same-sex behaviour, marginalisation, social stigma, maladaptive coping, and limited access to culturally competent health services may further increase vulnerability of the affected groups [24]..

A Case Illustration from Sri Lanka

Two young males, aged 19–20 years, voluntarily presented to a private community medical service seeking counselling and comprehensive screening for HIV and other STIs. Both individuals reported attending a pop-up club party event in an urban setting, promoted through private informal social networks, which was a novel experience for them. During the event, peers introduced them to recreational substances, with drug use taking place in a socially and sexually charged party environment. Under the influence of these substances, both individuals described impaired judgement and reduced inhibitions, which ultimately led to sexual encounters with previously unknown persons. These encounters included condomless oral sexual exposure. Neither individual reported prior drug use or previous sexual experiences, highlighting their relative inexperience and vulnerability in such settings.

In the days following the event, both men experienced marked anxiety, guilt, and fear related to potential HIV and STI acquisition. This psychological distress prompted them to proactively seek medical advice, counselling, and screening. Baseline investigations for HIV and common STIs were negative. However, both required risk assessment, post-test counselling, and structured follow-up to account for diagnostic window periods. In addition to biomedical care, counselling focused on risk perception, life skills, including decision making on substances and sexual matters, and strategies for harm reduction.

This case illustration demonstrates how chemsex-related environments can act as an entry point to high-risk sexual behaviour among young men with limited prior exposure to both substance use and sexual activity. It accentuates the role of peer influence, novelty-seeking risk behaviour, and impaired decision-making in facilitating risk. It also highlights the importance of accessible, non-judgemental sexual health services capable of addressing the intersecting needs of substance use, mental wellbeing, and STI/ HIV prevention.

Prevention and Public Health Response

Addressing chemsex in Sri Lanka requires a multi-sectoral approach. Integrating research on SDU into behavioural surveillance and routine clinical assessments is a critical first step to understanding the magnitude of the problem. Healthcare providers should be trained to sensitively enquire about drug use in sexual contexts, particularly when managing MSM and other key populations.

Prevention strategies should include targeted risk communication on the combined risks of substance use and sexual exposure, promotion of consistent condom use, regular HIV and STI testing, and linkage to pre-exposure prophylaxis (PrEP) where available [25]. Harm reduction approaches, including information on safer substance use, overdose prevention, and mental health support, are essential to reduce immediate and long-term harms [26].

Community-based stigma reduction towards people living with HIV and MSM will play a pivotal role in preventive efforts. Creating safe spaces for counselling and support can encourage early help-seeking and sustained engagement with care.

Although intravenous drug use has traditionally been recognized as the primary mode of HIV transmission among people who use drugs, the emerging practice of chemsex, particularly

involving crystal methamphetamine administered orally, smoked, or snorted in addition to intravenous route, has become an increasingly important factor to consider in HIV prevention and health promotion strategies. At a policy level, recognising chemsex as an emerging public health concern within national HIV and drug control strategies is crucial for resource allocation and programme development [8, 9].

CONCLUSION

SDU and chemsex represent an under-recognised but potentially significant driver of HIV and STI transmission in Sri Lanka, particularly among MSM. The hidden nature of the burden, shaped by stigma and limited data, should not delay action. As Sri Lanka continues its efforts to control HIV and improve sexual health outcomes, it is timely to acknowledge and address chemsex through evidence-informed, culturally sensitive, and rights-based public health interventions.

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