

Beyond Risk Behaviour: Exploring the Relationship Between Drug Use and Unprotected Sexual Practices in LGBTQ+ Communities

A Contextual and Harm-Reduction Perspective

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Abstract

The relationship between drug use and unprotected or condomless sexual practices in lesbian, gay, bisexual, transgender, queer, and other sexually or gender-diverse communities is complex. Neither LGBTQ+ identity nor substance use automatically produces sexual risk. Associations arise through the pharmacological effects of particular substances, patterns of sexualized drug use, individual intentions, partner dynamics, access to prevention, and structural conditions such as stigma, criminalization, violence, and exclusion from affirming health services. This article examines how alcohol and other drugs may affect judgment, condom negotiation, consent, partner selection, session duration, medication adherence, and exposure to blood-borne or sexually transmitted infections. It also emphasizes that condomless sex is not uniformly equivalent to unsafe sex: HIV pre-exposure prophylaxis, effective treatment with viral suppression, mutually understood agreements, vaccination, testing, and other prevention strategies can substantially change risk. Research is concentrated on gay, bisexual, and other men who have sex with men, while evidence concerning lesbian and bisexual women, transgender men, nonbinary people, and geographically diverse populations remains limited. Effective responses should combine culturally competent sexual-health care, nonjudgmental substance-use assessment, condoms and lubricants, HIV and STI testing, pre- and post-exposure prophylaxis, sterile injecting equipment, overdose prevention, consent support, and treatment when substance use becomes problematic. A rights-based harm-reduction approach replaces moral judgment with accurate information, autonomy, safety, and accessible care.

Keywords: LGBTQ+ communities, substance use, condomless sex, sexualized drug use, HIV prevention, STI prevention, harm reduction

Introduction

Sexual health and substance use are both shaped by personal choice, relationships, social environments, and access to care. Their intersection in lesbian, gay, bisexual, transgender, queer, and other sexually or gender-diverse (LGBTQ+) communities has often been described through the language of risk. That language can identify preventable harm, but it can also reinforce stereotypes if it presents LGBTQ+ identity as the cause of substance use or condomless sex. LGBTQ+ communities are diverse, and most members do not share the same behaviors, exposures, or health needs.

A more accurate analysis asks when, how, and under what conditions alcohol or other drugs influence sexual decision-making. It also recognizes the structural pressures surrounding those decisions. Minority stress theory explains how discrimination, anticipated rejection, concealment, and internalized stigma can contribute to psychological distress and health disparities (Meyer, 2003). Reviews of transgender populations, for example, link substance-use patterns with discrimination, violence, unemployment, trauma, and limited access to inclusive services rather than with gender identity itself (Connolly & Gilchrist, 2020).

The term 'unprotected sex' is also imprecise. Condomless sex may involve substantial HIV or sexually transmitted infection (STI) exposure, but risk varies with the sexual act, partner status, prevention methods, viral suppression, and testing. This article therefore uses 'condomless sexual practices' when referring specifically to absence of a condom and reserves 'higher-risk practice' for situations in which multiple protective measures are absent or impaired. This distinction supports scientifically accurate and nonjudgmental discussion.

Understanding the Substance Use–Sexual Health Relationship

Substances differ in their effects, route of administration, duration, and social meaning. Alcohol may reduce inhibition and impair attention to previously intended protection. Stimulants may prolong wakefulness and sexual activity, increase confidence, and delay recognition of exhaustion. Sedatives may impair memory, balance, and capacity to communicate consent. Injected substances introduce additional risks if equipment is shared. The relationship is not automatic: dose, tolerance, polydrug use, mental health, expectations, partner behavior, and setting all influence outcomes.

Sexualized drug use (SDU) refers broadly to the intentional use of alcohol or other drugs in connection with sexual activity. 'Chemsex' is a more specific and context-dependent term, commonly used for planned sexual activity involving particular drugs among some gay, bisexual, and other men who have sex with men (GBMSM). Maxwell et al. (2019) found wide variation in definitions and prevalence estimates, while identifying associations with condomless anal intercourse, unsafe injecting, and psychosocial difficulties among a minority of men. The term should not be applied indiscriminately to all substance use before sex or to all LGBTQ+ populations.

Pathways Linking Drug Use and Condomless Sex

Decision-Making and Prevention Intentions

Intoxication may shift attention toward immediate reward and away from plans formed when sober. A person who intended to use a condom may not have one available, may apply it incorrectly, or may abandon it during a prolonged encounter. Substances can also affect negotiation when partners have different preferences. However, condomless sex may be deliberately chosen rather than impulsive. Research should distinguish planned practices, intoxication-related changes, and situations involving coercion, because they require different interventions.

Association does not prove that drug use caused a particular sexual act. People who participate in larger sexual networks or certain venues may have greater opportunities for both drug use and condomless sex. Mental-health symptoms, sensation seeking, relationship context, or economic vulnerability may influence both. Longitudinal and event-level methods are more informative than a single cross-sectional question because they examine whether substance use and condomless sex occurred during the same event and in what sequence.

Consent, Communication, and Partner Dynamics

Valid consent must be voluntary, informed, specific, and revocable. Intoxication can create uncertainty about capacity and memory, particularly when substances cause sedation, confusion, or loss of consciousness. Unequal power, financial dependence, fear of rejection, and violence may further constrain negotiation. Harm reduction should include communication about boundaries before substance use, regular checking during encounters, recognition that silence is not consent, and clear plans for seeking help. Services should respond to sexual assault without blaming the person for substance use.

Partner type also matters. Condom decisions within a trusted relationship may be based on testing, exclusivity agreements, pre-exposure prophylaxis (PrEP), or the viral load of a partner living with human immunodeficiency virus (HIV). With effective antiretroviral therapy (ART) and sustained viral suppression, sexual transmission of HIV is effectively zero, supporting the principle undetectable equals untransmittable (U=U) (Rodger et al., 2019). U=U does not prevent other STIs, and it applies only when viral suppression is achieved and maintained.

Evidence Across Diverse LGBTQ+ Populations

Much of the literature focuses on men who have sex with men (MSM), especially in urban, high-income settings. In East and South Asia, Nevendorff et al. (2023) found SDU associated with greater odds of condomless anal intercourse and diagnosed HIV, while also reporting substantial heterogeneity in definitions and study methods. European research has similarly linked some SDU patterns with HIV/STI-related behaviors (Guerras et al., 2021). These associations identify groups who may benefit from tailored services; they do not imply that most MSM use drugs during sex.

Evidence for transgender people points strongly toward structural determinants. Connolly and Gilchrist (2020) found substance use correlated with transphobic discrimination or violence, unemployment, sex work, and intersecting minority status. Stigma may affect HIV testing, PrEP access, trust in clinicians, and willingness to disclose sexual or drug-use practices. Gender-affirming, trauma-informed care is therefore an essential component of sexual-health and substance-use services.

Lesbian and bisexual women, transgender men, nonbinary people, intersex people, and LGBTQ+ individuals in rural or low-resource settings remain underrepresented. Pregnancy potential, reproductive coercion, vaginal or frontal sex, shared sexual devices, and substance-related vulnerability may be overlooked when programmes equate LGBTQ+ sexual health only with anal sex among men. Research and services should ask about anatomy, practices, partners, and prevention needs without assuming them from identity labels.

Prevention in the Era of PrEP, PEP, and U=U

Condoms remain a central multipurpose prevention method. The World Health Organization (WHO, 2025b) states that correct and consistent use is highly effective against most STIs and HIV. Water- or silicone-based lubricant can reduce friction and condom breakage, especially during anal sex. Internal and external condoms should be offered without pressure, alongside practical instruction and options that support comfort and pleasure.

PrEP uses antiretroviral medication to prevent HIV acquisition among people without HIV. It should be discussed as one element of comprehensive prevention, with adherence support, periodic HIV testing, STI screening, and individualized follow-up. Substance use does not disqualify a person from PrEP. However, some patterns may complicate daily adherence or continuation, so flexible service models and long-acting options may be helpful (Viamonte et al., 2022). PrEP prevents HIV but not other STIs or pregnancy.

Post-exposure prophylaxis (PEP) is an emergency option after a possible HIV exposure and must be started as soon as possible, no later than 72 hours, according to current guidance (Centers for Disease Control and Prevention [CDC], 2024). People need advance awareness of where PEP is available, particularly after condom failure, shared injecting equipment, or sexual assault. Regular exposure is better addressed through PrEP and an ongoing prevention plan rather than repeated reliance on PEP.

HIV and STI testing should be voluntary, confidential, affordable, and matched to exposure sites. Depending on practices, testing may require genital, rectal, and pharyngeal specimens rather than urine or blood alone. Vaccination against hepatitis A, hepatitis B, and human papillomavirus should be offered according to national guidance. For people living with HIV, rapid linkage to ART supports individual health and U=U. Prevention counseling should explain these choices without presenting any single method as morally superior.

A Harm-Reduction Response to Substance Use

Harm reduction accepts that some people will continue using substances and seeks to reduce preventable injury while respecting autonomy. A useful assessment asks what is used, how much, how often, by which route, in what setting, and with what desired and undesired effects. It should explore blackouts, withdrawal, overdose, injecting, consent difficulties, sexual-health outcomes, mental health, medication interactions, and the person's own goals. Not every use pattern constitutes a disorder, and treatment should not be imposed merely because use occurs in a sexual context.

Practical measures include avoiding unknown drug combinations, not using alone, maintaining hydration without excessive water intake, planning rest, using sterile injecting equipment, never sharing needles or other equipment, and ensuring access to overdose-response resources appropriate to the local drug supply. A trusted contact or agreed safety plan can help when sessions are prolonged. Clinical advice is essential because risks vary widely across substances and combinations.

When use becomes compulsive, causes loss of control, disrupts work or relationships, or repeatedly leads to unwanted outcomes, accessible treatment should be offered. Effective care may combine motivational interviewing, cognitive-behavioral approaches, peer support, mental-health treatment, and medication for specific substance-use disorders. Integration with sexual-health services reduces the burden of visiting multiple stigmatizing systems. WHO (2025c) recommends that HIV prevention for key populations include condoms and lubricants, HIV and STI testing, PrEP, PEP, and harm-reduction services.

Awareness, Attitudes, and Correlational Research

A correlational investigation can examine whether knowledge and perspectives are associated with drug use, condomless sex, testing, PrEP, or harm-reduction practices. Awareness should include transmission routes, condoms and lubricant, PrEP, PEP, U=U, STI screening, vaccination, overdose prevention, and consent. Perspective measures may assess perceived susceptibility, perceived benefits and barriers, stigma, trust in services, self-efficacy, partner communication, and harm-reduction acceptability.

Measurement should be behaviorally specific and time bounded. Researchers should distinguish alcohol, stimulants, sedatives, inhalants, opioids, cannabis, and injected drugs; frequency of use is not equivalent to sexualized use. Sexual measures should specify acts, partner types, condoms, PrEP, viral suppression, and whether the behavior occurred during the same event as substance use. Combining all LGBTQ+ participants into one category can conceal important differences. Stratified analysis should be planned only where sample sizes protect validity and confidentiality.

Cross-sectional correlation cannot establish causation or direction. Self-report may be affected by recall, stigma, and fear of disclosure. Recruitment through clinics or social venues may exclude people with different

experiences. Researchers should use community input, inclusive language, private data collection, strong confidentiality, referral information, and a protocol for responding to violence, assault, overdose risk, or urgent health needs. Findings should be reported without implying that identity itself is pathological.

Implications for Health Services and Policy

Services work best when they are affirming, confidential, integrated, and practical. Staff require training in sexual orientation, gender diversity, substance use, consent, and trauma-informed communication. Clinic forms should allow accurate self-description while asking separately about anatomy and behavior relevant to care. Community-led outreach, peer navigation, mobile testing, telehealth, and low-threshold services may reach people who avoid conventional clinics because of past discrimination.

Policy should address structural vulnerability alongside individual behavior. Criminalization, housing instability, unemployment, violence, and discrimination can push sexual and drug use into less safe settings and deter help-seeking. UNAIDS (2024) emphasizes that stigma and human-rights barriers undermine the HIV response. Prevention programmes should therefore measure respectful access, service retention, and community trust—not only changes in condom use.

Digital and Community Contexts

Dating applications and online networks can facilitate connection, sexual-health information, partner communication, and access to affirming communities. They may also increase the speed with which partners or substance-using events are arranged. Digital platforms should not be treated as causes of risk; their effects depend on users, settings, and available safeguards. Prevention initiatives can work with community organizations and platforms to provide discreet information about PrEP, PEP, testing, consent, overdose response, and local services. Community venues can distribute condoms, lubricant, sterile equipment, and referral information without requiring disclosure of identity or behavior. Messages are more credible when designed with LGBTQ+ people who have lived experience of substance use and sexual-health services. Participatory design also helps programmes acknowledge pleasure, intimacy, and belonging rather than communicating only danger. This approach can improve relevance while identifying unintended consequences, such as privacy concerns, surveillance, or exclusion of people without reliable internet access.

Conclusion

The relationship between drug use and condomless sexual practices in LGBTQ+ communities is real in some contexts but cannot be reduced to identity or individual irresponsibility. Pharmacological effects, sexual intentions, consent, partner dynamics, minority stress, economic conditions, and access to prevention interact. Condomless sex is not uniformly unprotected when PrEP, sustained viral suppression, testing, vaccination, and negotiated agreements are present, although protection against other STIs may still be needed. Effective responses combine accurate information, condoms and lubricant, PrEP and PEP, U=U education, site-specific testing, sterile equipment, overdose prevention, affirming treatment, and structural reform. Moving beyond risk behavior means centering dignity, pleasure, autonomy, and safety while ensuring that people can obtain care without judgment.

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