

Post-Script to the Crack Epidemic and Its Links to HIV

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Abstract

Sex-for-drugs and money exchanges have been demonstrated to be the vital link between the crack cocaine epidemic and accelerated rates of HIV infections among inner-city young adults in the United States. This paper explores the inadvertent public policy contributions that have reinforced this link and subsequent spread of HIV. It is our hypotheses that the unaddressed crack epidemic has facilitated the continued transmission of HIV in the lowest-income communities; that the AIDS epidemic has now dispersed from low-income central city communities to low-income suburban communities; and that HIV risks for low-income suburban Whites have increased dramatically. Renewed epidemiological attention is needed.

Keywords: crack cocaine, HIV, African American, sex exchanges, public policy

Prelude to Crack

When AIDS first struck white gay men in the early 1980s, its impact was devastating and well publicized. But by the mid-1980s, a less well publicized and equally devastating AIDS epidemic was underway among black heroin injection drug users (IDUs). The National Institute on Drug Abuse (NIDA) organized the first multi-site national HIV epidemiological study of IDUs and their sex partners, called the National AIDS Demonstration Research (NADR) project (McCoy & Rivers, 1993). Very little was known about IDUs' HIV risk taking. IDUs were underrepresented in household surveys and hospital-based studies. It was necessary to use ethnographic observations to develop initial hypotheses about IDUs HIV risks to study them systematically. Two challenges had to be overcome. The first was to successfully work in low-income black communities (Valentine, 1968), and second was to gain access to the hidden world of

IDUs within these communities (McCoy and Rivers, 1993).

In all of the NADR sites, IDUs were observed exchanging needles and syringes. If these needles and syringes were cleaned, it was with water. This is an ineffective way to remove HIV contaminated blood from the syringe and was hypothesized as the way that HIV was passed from injector to injector. In the systematic interview phase of NADR in which blood was drawn from IDUs respondents and tested, this observation was

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confirmed. The higher the rate of un-cleaned needles shared among IDUs the higher the HIV rate (Gostin, Lazzarini, Jones, & Flaherty, 1997). Since readily available household bleach kills HIV, the prevention mantra to injectors quickly became to thoroughly clean their needles and syringes with bleach before exchanging them with others (Broadhead, 1991).

It turned out that the spread of HIV among injectors through needle sharing was only part of the problem. NADR ethnographies and systematic interviews also established that the sexual behavior of HIV infected IDUs posed a second risk (Staff, 1998). Most injectors' sex partners were non-injectors. So, now a second and more complex prevention challenge began – how to get injectors to also use condoms. But just as ethnographic interest began to focus on IDUs' sexual behavior there was yet a new development. Crack cocaine appeared across the U.S. around 1986 and heroin IDUs were among the first to use crack (Cooper, 2002). Injectors who used crack began reporting dramatic increases in their numbers of sexual partners.

Intersecting Epidemics

IDUs knew where all the initial crack dealing took place and led investigators to them. In these sales locations, teens became the focus of attention. In our first ethnographies on crack use, several teen informants were asked why there were no women dealing crack (Bowser, 1989). The response was “they don't have to ... they can just give it up' as part of their payment.” This was the first indication that sex had become a currency of exchange in this epidemic. Furthermore, other informants who used crack claimed that the drug enhanced their sexuality; they wanted to have sex more often and with more partners. The presence of injectors as initial customers and partners in sexual exchanges was particularly disturbing.

Perhaps these reports were simply episodic and characteristic of this one location in San Francisco's Bayview. The

follow-up to this observation was the first systematic study of HIV risk behavior among crack using adolescents – in San Francisco's Bayview and across the Bay in Oakland where crack dealing was particularly intense. In a sample of 222 black teens who used crack, those who combined sex with crack use were more likely to report a history of sexually transmitted diseases (STDs) than those who did not (Fullilove, Fullilove, Bowser, & Gross, 1990). Those who sold crack reported even higher HIV sexual risks and numbers of STDs. Given the participation of injectors in the new crack trade, it was just a matter of time before HIV would show up among the teens engaged in crack sex exchanges.

Our concerns were shared by others. Across the country others were making similar observations. The U.S. Center for Disease Control and Prevention (CDC) began a multi-city study of HIV risks focused on crack cocaine use. This study established that the sexual exchanges for drugs and money among crack dealers and users could dramatically expand the AIDS epidemic, in particular, in black communities (Edlin et al., 1994; Edlin et al., 1992; Irwin et al., 1996). Based upon interviews of 2,323 young adults from inner-city neighborhoods in Miami, New York and San Francisco, 15.7 percent of the crack smokers were HIV positive in comparison to 5.2 percent of non-smokers. The highest HIV rates were among women who had exchanged sex-for-money or drugs; 30.4 percent were HIV infected in comparison to a 9.1 percent infection rate for women who had not engaged in exchanges. The connection between crack use and inevitability of accelerating the AIDS epidemic was now clearly evident.

Generally, when such a danger to public health is found and verified, aggressive preventive actions are taken. First, aggressive community-based outreach was needed to reach crack cocaine users to warn them about their HIV risks. Condom distributions started for injectors needed to be quickly expanded to crack users. Second, interventions were needed to address sex-for-money and drug exchanges in crack dealing;

whatever could be done to stop this practice needed to happen. Third, HIV testing and counseling needed to be expanded to include crack users. Testing is an excellent way to keep HIV risk potential prominent in risk-takers' mind. Fourth, the crack epidemic exposed the fact that there was no known treatment modality for cocaine addiction. It was insufficient to just include crack users in the same treatment with heroin users. The drugs are different and the social practices associated with the use of each drug are different enough to require distinct approaches to treatment. Finally, it was clear that crack cocaine use, especially for the women who had to engage in sex exchanges, was a traumatic experience that would require trauma counseling and services.

What Happened

Despite the clear risk of a rapidly expanding AIDS epidemic, the dangers that crack posed to public health were overlooked (Watkins, Fullilove, & Fullilove, 1998). More than ten years passed before there was an expansion of community health outreach to crack cocaine users. It took as long for CDC or NIDA to call for proposals to intervene specifically in crack sex exchanges for money or drug. When action was finally taken there were only a few evidence-based targeted interventions developed such as the Women's Co-Op and the Treatment Access project in Nashville (Okpaku et al., 2010; Wechsberg, Lam, Zule, & Bobashev, 2004). In the ten years before these targeted efforts, community-based agencies expanded HIV counseling and testing, but only because those engaged in testing IDUs expanded their work to crack users – and without increased funding. Because there were no treatment modalities for cocaine addicts and because so many IDUs also used crack, experiments began with methadone, initially developed for opiate users, as a treatment for cocaine addiction (Bravo et al., 2010; Oliveto et al., 2010). Finally, no specific national attention was given to crack-using women as victims of sexual exploitation and trauma due to sex exchanges (Fullilove, Lown, Fullilove, 1992;

Fullilove et al, 1993). In fact, when the initial sex exchanges for drugs and money were initially described, there was denial that they existed (Sterk, 1988). The first full ethnographies on these exchanges came more than a decade after exchanges had begun (Sharpe, 2005; Sterk, 2000).

In the CDC's review of their response to the HIV/AIDS crisis among blacks, no mention is made of a targeted response to crack-driven sex exchanges (Sutton et al., 2009). Based on NHBS data from 2006-7, crack driven sex and drug exchanges were dismissed as factors in the continuing HIV epidemic (2011). Instead of a national public health effort to stop the AIDS threat posed by crack exchanges for sex and money, a national hysteria developed (Belenko, 1993). Newspapers and television covered the "in your face" aspect of street drug dealing, the drive-by shoots and the initial inability of the police to deal with it. There were reports of teenagers making thousands of dollars per day dealing crack. The impression was given that low-income black communities were overrun by drug dealers and one could be a victim of a drive-by shooting at any time and place. People literally stopped driving through these communities and property values dropped. Community-based outreach and treatment actually declined.

To get new funding and renewed attention in 1998, community AIDS activists and public health departments had to call health states of emergency (Staff, 1998). But the boost from this measure was short-lived (Laurencin, Christensen, & Taylor, 2008). Instead, there was a massive expansion in the numbers, fire-power and ability of police to pursue and arrest street-level crack dealers (Schneider, 1998). The only people who had any capacity to respond to the public health emergency were the police.

The Scope of Crack Dealing and Its Effects

The general "hysteria" over crack led to a belief that crack dealing and the violence associated with it were omnipresent in black communities. The fact is that actual public

drug dealing and use were confined to a small number of specific locations. An unpublished study conducted in Oakland, California identified the locations, scope and organization of crack cocaine dealing. The purpose of the study was to identify for a community-based Robert Wood Johnson Fighting Back project where and how it might creatively and most effectively intervene in drug dealing and use. It found that out of 652 face-blocks in East Oakland only 52 had any kind of visible street-level drug dealing. Of these 52 face-blocks only five accounted for large scale sales. All five were within five blocks of freeway entrances and exits. At these sites, the vast majority and most profitable drug sales were made to people who drove off and then back onto the highway. The forty-seven other sites catered to a mix of drive-up and local buyers. The same limited numbers of crack dealing locations were observed in other U.S. cities as well (Bowser, Quimby, & Singer, 2007). By 1995, newly invigorated police departments across the country managed to “take down” street-level crack dealing.

By the year 2000, the damage was done. But the CDC study reports odd news (CDC, 2011). There was no significant difference in HIV prevalence by race or ethnicity in low income urban areas where at least 20 percent of residents have household incomes below the U.S. Census Bureau’s definition of the poverty line. This finding seems to contradict long term national statistics showing HIV prevalence among blacks as eight times higher than it is among whites in 2010 (6 times higher in 2006). For Hispanics HIV prevalence is three times higher than it is among whites in 2010. Poverty, not race, appears to be the main driving force that exposed community residents to HIV infection.

But behind this finding is that during the 1990s, over one million HIV infections occurred among African Americans, most of which could have been prevented. Many low-income black communities across the U.S. now have HIV epidemics extensive enough to meet the United Nation’s Joint Program on HIV/AIDS (UNAIDS) definition

of a generalized epidemic: 1) that the prevalence of HIV is more than one percent in the general population; and 2) that the transmission of HIV is now sufficient to sustain an epidemic independent of the initial groups that introduced HIV to the community (Denning & DiNenno, 2010).

This seeming contradiction between prevalence in poverty communities and national HIV prevalence can be explained. It is the higher prevalence of crack cocaine use among Blacks and Hispanics that links already existing infections among MSMs and IDUs with young adult crack users in crack exchanges for drugs and money. The new CDC study missed the crack link between a generalized HIV epidemic and Blacks. It is our hypothesis that the unaddressed crack epidemic with sex and drug exchanges has facilitated the transmission of HIV in the lowest-income black communities. Two decades ago in 1992 and 1993, HIV seroprevalence in 16 U.S. municipalities was 12.7 percent among IDUs and 7.5 percent among crack smokers due to sexual high risk behaviors (Kral, Bluthenthal, Booth, & Watters, 1998). From 1999 to 2004, 73 percent of all diagnoses of heterosexually acquired HIV ($n = 52,569$) in the U.S. consisted of non-Hispanic blacks (Espinoza et al., 2007); these people were infected during the height of the crack epidemic.

Did the Crack Epidemic Run Its Course?

By the year 2000, street-level crack cocaine dealing disappeared as quickly as it started. Perhaps the police response succeeded in ending street trafficking and discouraged further crack cocaine dealing. All who dared to sell the drug in public went to jail. However it happened, City Halls across the country claimed victory and embattled communities felt that they had regained control of their streets and were relieved. An alternative view is that like all epidemics crack ran its course (Musto, 2002). Potential new users saw what crack did to those who used it. So they rejected it and chose an alternative drug. About this time, outreach workers started getting reports

of drug users trying methamphetamine or going back to heroin.

It is our view that crack cocaine use did not run its course nor were its sales successfully suppressed. Based upon continued ethnography and interviews with the few remaining health outreach workers in the field, crack cocaine dealing and use has not declined from its 1990s scale. Only the way in which it is dealt has changed. Crack trafficking has dispersed and gone underground. In doing so, the trade has taken its HIV risk, sex-exchange-for-drugs-and-money, along with it. Consider the following.

Since 1986 Congressional legislation, the possession of five grams of crack more often sold by black youth carried the same penalty as 500 grams of cocaine more often sold by whites, and a five-year mandatory minimum. It took fifty grams of crack, or 5,000 grams of cocaine, to get a 15-year minimum sentence (Schneider, 1998). [This disparity was reduced to 1:18 from 1:100 when President Obama signed the Fair Sentencing Act of 2010.] With mandatory sentences from five to 15 years, the first wave of young adults who were arrested and served time for dealing crack had plenty of time to reflect on their drug dealing and to discuss it with one another. Young crack dealers concluded that their mistake was not dealing drugs or getting caught. Their mistake was being so visible in their dealing. The “in your face” drug dealing and turf wars against one another alienated the larger community, kept attention on them and demanded a police response. They would have been better off hiding their trade and trying to be as invisible, the way heroin dealers were. About the same time, pagers and cell-phones became available. When this first wave of dealers was released, many went back to dealing crack. But instead of standing on street corners attracting attention, customers and arrest, they did something different. They gave customers pager and cell-phone numbers and then arranged to meet them at many different locations to sell crack. Now crack dealing

could go on any place at any time, especially outside of low-income black communities where it is least expected.

In invisible crack dealing, money and drugs can be exchanged in malls, stores, restaurants, at movie theatres, at bus-stops, on the bus or on any random street corners. There are even home deliveries. The new trade renders crack trading virtually impossible to predict, follow, see and most importantly, to bust. The police cannot follow the new dealing and the public is led to believe that this dealing no longer exists. This is a major change because it means that it is no longer necessary to confine drug dealing to black communities or to black young people as dealers. Using pagers and cell-phones changed all of this by largely removing the danger and risk involved in dealing. Suburban dealers no longer have to drive into inner city black communities at night to get their supply of drugs. They could meet suppliers any place and deal directly from within their own communities.

Gentrification is another development that has dispersed drug trafficking from black communities and helped to push it underground. In the Bay Area, by the middle of the 1990s crack epidemic, Black community property values had dropped so low that it created a market for Asian and Hispanic immigrant first-time home buyers. Language and cultural barriers insulated the new immigrant residents from both the danger of crack trafficking and concern with community stigma. They could walk by drug dealings, move next door to crack-houses and go about their business as if in another world. Immigrant home owners opened the door for white “urban pioneers.” These people realized that drug dealing and shootings happened in only a small part of black communities as illustrated in the Oakland study. The increased presence of white pioneers put additional pressure on the police to deal with drug trafficking. The police began to constrict where drug dealing could take place. The number of public spaces -- streets, corners, parks -- where one could deal drugs declined and those sites that remained became more competitive,

dangerous and exposed to police interventions.

Implications for HIV Risk

Did changes in drug trafficking affect HIV risks? Have sex-exchanges-for-drugs-and-money declined and disappeared with the reorganization and dispersal of the trade? The answers to these questions may be emerging from an unlikely place. The underground crack-HIV connection is now extensive enough to show up for the first time in the combined 2005 to 2008 National Household Survey on Drug Use and Health. In Table One, three percent of blacks who reported ever using crack were HIV positive compared to one-tenth percent of blacks who never used crack ($p < .0001$). Blacks in cities of over one million residents with incomes below \$20,000 and who were males were more likely to be HIV positive as well ($p < .0001$). While small, three percent more than fulfills the UNAIDS definition of a generalized epidemic in the lowest-income black communities. The only thing that connects crack with HIV are exchanges for drugs and sex.

But what is unexpected in Table One is that six-tenths percent of the general population (non-blacks) who reported ever using crack were HIV positive compared to one-tenth percent of those who never used crack ($p < .0001$). Crack even has a statistically significant presence as a marker of HIV infections among whites. Otherwise, there were no significant differences in HIV status by population density, family income or gender in the general population. Logistic regression analyses in Table Two show that blacks who use crack are seventeen times more likely to be HIV positive than blacks who never used crack ($p < .0001$). In the general population those who use crack were six times more likely to be HIV positive than those who never used crack ($p < .0001$). Among those who use crack, HIV has a significant presence, and it is our hypothesis that the higher rates among blacks are associated with sex and drug exchanges.

A recent MMWR Report suggests that those who use crack or exchange sex-for-drugs are still contributing to the HIV/AIDS epidemic. Almost four percent (3.7%) of those who exchanged sex partners in the 12 months prior to their interview and blood test were infected as were 6.3% of those who used crack (CDC, 2011). HIV levels for those who do both is likely to be even higher. When one considers that injection drug users who might also use crack are greatly under-reported in national surveys, the only way remaining for these people to become HIV infected is through sexual contact.

There has been no recent funding for ethnographic or systematic research to monitor crack-related drug exchanges such as the National Household Survey on Drug Use and Health. An attempt was made in the mid-1990 using a rapid response and rapid assessment ethnographic strategy to identify new HIV risks in eleven U.S. cities (Bowser et al., 2007). In a number of cities, locations where one could find public drug dealing and use and sex-related HIV risk behaviors were appearing further and further away from downtown and closer to mixed racial low-income suburban communities. But there has been no interest in continued funding of even inexpensive explorations of HIV risks during the Bush or Obama administrations. From an epidemiological standpoint, we are back to the beginning of the crack epidemic.

Conclusion

Our central point is that sex exchanges for drugs and money are still going on in central city low-income black communities and are now also shifting to suburban low-income communities. What we strongly suspect is that the racial sentencing disparity has negatively impacted our ability to address the HIV outcome of crack exchanges. Interestingly, the connection between special legal sentencing for crack cocaine and a deepening AIDS epidemic among Blacks has been dutifully mentioned by National Institute on Drug Abuse (NIDA) directors at U.S. Sentencing Commission Public

Table 1. HIV Status by Crack Use and Demographic Factors: National Household Survey on Drug Use and Health (Combined 2005 – 2008 Data Sets)

		Blacks (N = 47,481)		Chi-Sq.	p <
Crack Use		Ever	Never		
	HIV Positive	3.0%	0.1%	435.4	0.0001
	HIV Negative	97.0%	99.9%		
Population Density					
		> 1 Million	< 1 Million		
	HIV Positive	0.3%	0.1%	14.2	0.0001
	HIV Negative	99.7%	99.9%		
Family Income					
		> \$20,000	< \$20,000		
	HIV Positive	0.1%	0.3%	16.9	0.0001
	HIV Negative	99.9%	99.7%		
Gender					
		Male	Female		
	HIV Positive	0.3%	0.1%	15.9	0.0001
	HIV Negative	99.7%	99.9%		
Non-Black (N = 331,642)					
Crack Use					
		Ever	Never		
	HIV Positive	0.6%	0.1%	342.3	0.0001
	HIV Negative	99.4%	99.9%		
Population Density					
		> 1 Million	< 1 Million		
	HIV Positive	0.1%	0.1%	56.2	0.0001
	HIV Negative	99.9%	99.9%		
Family Income					
		> \$20,000	< \$20,000		
	HIV Positive	0.1%	0.1%	20.8	0.0001
	HIV Negative	99.9%	99.9%		
Gender					
		Male	Female		
	HIV Positive	0.1%	0.0%	15.9	0.0001
	HIV Negative	99.9%	100.0%		

Table 2. Logistic Regression Analyses of HIV Status by Crack Use and Demographic Factors: National Household Survey on Drug Use and Health (Combined 2005 – 2008 Data Sets)

	Covariates	OR	95%CI	P <
Black HIV by:				
	Never/Ever Use Crack	17.4	11.4-26.5	0.0001
	Population Density	2.5	01.5-03.9	0.0001
	Gender	1.9	01.3-02.9	0.0010
	Family Income	2.2	01.5-03.3	0.0001
Non-Black HIV by:				
	Never/Ever Use Crack	7.9	5.9-10.4	0.0001
	Population Density	2.6	2.0-03.3	0.0001
	Gender	4.3	3.2-05.7	0.0001
	Family Income	1.8	1.4-02.4	0.0001

Hearings in 2002 and 2006 (Hanson, 2002; Volkow, 2006). This legislative driven sentencing is a factor in a continued AIDS epidemic which has been ignored by commissioners both times.

It is now 2014. Hopefully, the dispersal and expansion of underground crack dealing has dissipated the HIV risks. We know that HIV is more likely to spread where sex partners' social networks are insular and where the same people in the network have sex with one another. Belle Glade, Florida, is the classic example (McCoy et al., 1996; Swenson, 1992). The potential spread of HIV from central cities to the suburbs is just the opposite; it is a dispersion of risk. But in time even a dispersed risk can take root. The spread of HIV out of the Bronx to other New York City and New Jersey communities is now the classic case (Wallace & Fullilove, 1991).

HIV infected people were dispersed from the Bronx due to planned shrinkage in the 1970s; HIV was also dispersed and in time pockets of new infections developed outside of the Bronx. The dispersal of crack dealing and its expansion to suburban communities has the same potential.

In doing so, the stage may be set for future surprises – a rise of HIV infections in low-income suburban communities.

Given the changes that have occurred since systematic attention was last given to either the crack or HIV/AIDS epidemics in low-income communities, renewed attention is needed. We need new ethnographic studies in both low-income urban and suburban communities to re-explore relations between sex exchanges for money and drugs, drug dealing, HIV risks behaviors and HIV infections. Then, new epidemiological studies are needed to see to what extent these HIV behavioral risks have generated HIV infections among high risk takers and their sexual networks. Such systematic study done nationally in scope may very well uncover emerging patterns of a new and dispersed HIV/AIDS epidemic in the United States. Alternatively, if sex exchanges continue to be ignored and not addressed in epidemiological studies, we will not know how extensive they are or to what extent they are spreading HIV until it is too late.

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