

What are the HIV prevention needs of crack cocaine users?

University of California
San Francisco



Center for AIDS
Prevention Studies (CAPS)
Technology and Information
Exchange (TIE) Core

Prepared by Margaret R. Weeks PhD, Institute for Community Research
and Pamela DeCarlo, CAPS

Fact Sheet 66, December 2009

Is crack cocaine an issue?

Yes. Although many people think of it as a drug of the 80s, crack cocaine is still around. HIV prevention has traditionally focused on injecting drug use and other stimulants like methamphetamine. But many people use more than one drug and may be using these drugs in different ways, for example, smoking crack and injecting heroin. Crack use alone and crack use combined with other drugs present real risks for HIV transmission and acquisition.

Crack cocaine is a powerfully addictive stimulant drug. Crack is a rock crystal, which can be smoked or dissolved and injected. It is relatively cheap and readily available on the street in mainly low-income urban areas. Crack is highly addictive and the effects of the drug are short-lived (about 5 minutes), making it necessary to use more to maintain a high.

Recent studies of crack users show high rates of HIV infection. In Harlem, New York, 23.9% of users and sellers of crack were HIV+;¹ in Los Angeles, California, 24% of older low-income MSM were HIV+;² and 22.4% of female street sex workers in Miami, Florida were HIV+.³

These crack pipes can lead to cuts and burns on the lips, which are associated with HIV transmission.⁹ It is not known if this is due to sharing pipes between users or sexual transmission during oral sex. Some research shows possible risk of pneumonia and tuberculosis transmission through sharing of crack pipes as well.¹⁰

How does crack affect HIV+ persons?

Crack use affects HIV+ persons on many levels: biological, social and behavioral. On a biological level, crack use can accelerate HIV disease progression.¹¹ One study found that persistent crack users were over three times as likely to die from AIDS-related causes as non-users.¹²

On a social level, most crack users who are HIV+ live in disadvantaged and impoverished communities, which present a variety of barriers to health. Crack users with HIV are less likely than HIV+ non-users to have access to basic medical services and more likely never to have been in HIV primary care.¹³ They are less likely to have a regular healthcare provider and to initiate medical care and treatment.¹⁴

On a behavioral level, crack users have low rates of adherence to HIV therapy once they have begun treatment.¹⁵ And HIV+ crack users are more likely than HIV+ non-users to continue to engage in high risk sexual behaviors with HIV- or unknown status partners after learning their HIV status.¹³

Who uses crack?

While crack use may vary geographically by race, age and sexual orientation, most crack use is concentrated in inner city communities that are impoverished and disadvantaged and have limited access to many services. These are the same neighborhoods with high rates of unemployment, homelessness, violence, substance abuse, HIV, sexually transmitted diseases (STDs) and other risks. However, some crack users do not fit these characteristics and are still at very high risk of health related consequences of crack use.

How does crack affect HIV transmission risk?

Risk of HIV and other sexually transmitted diseases can vary by level of crack use and addiction. Crack's short-lived high and addictiveness can create a compulsive cycle in which users quickly exhaust their resources and turn to other ways to get the drug, including exchanging sex for money or drugs (such as a "hit" of crack).⁴ Trading sex in these circumstances often creates extremely risky situations that may include high numbers of partners, sex while under the influence and drug-related violence. This environment makes it hard to engage in safer behaviors and contributes to inconsistent condom use.^{5,6} In one study, HIV infection was associated with intensive, daily crack smoking among women engaged in survival sex.^{5,7}

Crack use is also associated with very high rates of other STDs, including syphilis, gonorrhea, and chlamydia. Lesions and abrasions associated with these infections increase opportunities for infection with HIV, especially during repeated or protracted sex, common among crack users.⁸

Crack is often smoked in make-shift pipes that use a glass pipette (tube) or a broken car antenna as a mouthpiece.

What's being done?

The Risk Avoidance Partnership (RAP) Project in Hartford, Connecticut, trained active drug injectors and crack users to deliver an HIV, hepatitis, and STD prevention intervention to hard-to-reach drug users both inside and outside of their networks. The Peer Health Advocates (PHAs) received training in risk reduction and health promotion, communication skills and the importance of health advocacy. Crack users in RAP helped to design special "crack kits" they distributed to encourage use of rubber tips on crack pipes; kits also included male and female condoms and "dental dams" (flat latex sheets for use when performing oral sex on women). Study participants reported significant risk reduction.¹⁶

Using a harm reduction model, a needle exchange program in Ottawa, Canada distributes safety kits to crack users to reduce the risk of cuts and burns and potential transmission from sharing crack pipes and to decrease needle sharing. The kits include glass stems, rubber mouthpieces, brass screens, chopsticks, lip balm and chewing gum. Recipients reported less injecting and less sharing of pipes.^{10,17}

JEWEL (Jewelry Education for Women Empowering their Lives) was an economic empowerment and HIV prevention project

for crack-using women involved in prostitution in Baltimore, Maryland. The JEWEL intervention used six 2-hour sessions that taught HIV prevention and the making, marketing and selling of jewelry. Women participants significantly reduced trading drugs or money for sex, the number of sex trade partners, and daily crack use.¹⁸

Two separate intervention trials compared a standard National Institute on Drug Abuse HIV prevention intervention to woman-focused, culturally-specific interventions for female African-American crack cocaine users. The two interventions were grounded in motivation and empowerment theories and addressed the reality of the daily lives of women and the violence and poverty of their inner-city neighborhoods. Women in the culturally-specific interventions reported more reductions in sexual risk behaviors¹⁹ as well as improvements in employment and housing status.²⁰

What still needs to be done?

While there is still no medical treatment for crack or cocaine abuse and dependence, several behavioral treatments have demonstrated efficacy for helping people to initiate abstinence and to prevent relapse to cocaine use. These include contingency management, cognitive behavioral therapy, and motivational interviewing.²¹ Currently available treatment for crack dependence tends to be limited to 12-step programs, which have little evidence of efficacy. Further development and testing of efficacious behavioral and medical treatments

are needed to help crack users overcome the intense cravings associated with crack addiction.

Federal sentencing laws currently give far harsher penalties for crack cocaine than for powdered cocaine.²² Using a 100-to-1 ratio, a person who sells a small amount of crack receives the same sentencing as a person who sells 100 times that amount of powder cocaine, resulting in prisons packed with low-level, predominantly African American offenders. In 2008, over 80% of offenders sentenced for crack-related federal crimes were Black and 10% were White. Activists and legislators are working to change the legislation, and to make it retroactive for those currently incarcerated.²³ Stronger public policy around sentencing guidelines are needed.

Substance use is complicated and HIV prevention has tended to simplify efforts into either reducing needle sharing and needle use, or reducing sexual risk. However, many IDUs also use crack, and often smoke crack when they've stopped injecting. Programs for IDUs should address poly-drug use, including crack use, and sexual risk reduction in the context of complex psychological and social needs and pressures associated with addiction.

Crack users face a variety of barriers to remaining healthy, and programs need to take a more holistic approach to prevention.²⁴ Crack users often need basic services such as childcare, safe shelter, food security, basic necessities and substance abuse treatment before they can think about HIV prevention.²⁵ Interventions should not simply focus on drug and sex risks, but should address these basic survival needs as well as education, employment, housing and job training.

Says who?

1. Davis WR, Johnson BD, Randolph D, et al. Risks for HIV infection among users and sellers of crack, powder cocaine and heroin in central Harlem: Implications for interventions. *AIDS Care*. 2006;18:158-165.

2. Ober A, Shoptaw S, Wang PC, et al. Factors associated with event-level stimulant use during sex in a sample of older, low-income men who have sex with men in Los Angeles. *Drug & Alcohol Dependence*. 2009;102:123-129.

3. Inciardi JA, Surratt HL, Kurtz SP. HIV, HBV, and HCV infections among drug-involved, inner-city, street sex workers in Miami, Florida. *AIDS and Behavior*. 2006;10:139-147.

4. Edwards JM, Halpern CT, Wechsberg W. Correlates of exchanging sex for drugs or money among women who use crack cocaine. *AIDS Education and Prevention*. 2006;18:420-429.

5. Sharpe TT. *Behind the eight-ball: Sex for crack cocaine exchange and poor Black women*. Taylor and Francis, New York. 2005

6. Sterk CE, Elifson KW, Theall KP. Individual action and community context: The health intervention project. *American Journal of Preventive Medicine*. 2007;32:S177-S181.

7. Shannon K, Bright V, Gibson K, et al. Sexual and drug-related vulnerabilities for HIV infection among women engaged in survival sex work in Vancouver, Canada. *Canadian Journal of Public Health*. 2007;98:465-469.

8. Miller M, Liao Y, Wagner M, et al. HIV, the clustering of sexually transmitted infections, and sex risk among African American women who use drugs. *Sexually Transmitted Diseases*. 2008;35:696-702.

9. Theall KP, Sterk CE, Elifson KW, et al. Factors

associated with positive HIV serostatus among women who use drugs: continued evidence for expanding factors of influence. *Public Health Reports*. 2003;118:415-424.

10. Johnson J, Malchy L, Mulvogue T, et al. Lessons learned from the SCORE project: A document to support outreach and education related to safer crack use. June 2008. http://nexus.ubc.ca/documents/Newsletters/SCORE_Report_FINAL.PDF

11. Baum MK, Rafie C, Lai S, et al. Crack-cocaine use accelerates HIV disease progression in a cohort of HIV-positive drug users. *Journal of AIDS*. 2009;50:93-99.

12. Cook JA, Burke-Miller JK, Cohen MH, et al. Crack cocaine, disease progression, and mortality in a multicenter cohort of HIV-1 positive women. *AIDS*. 2008; 22:1355-1363.

13. Metsch LR, Bell C, Pereyra M, et al. Hospitalized HIV-infected patients in the era of highly active antiretroviral therapy. *American Journal of Public Health*. 2009;99:1045-1049.

14. Cunningham CO, Sohler NL, Berg KM, et al. Type of substance use and access to HIV-related health care. *AIDS Patient Care and STDs*. 2006; 20:399-407.

15. Moss AR, Hahn JA, Perry S, et al. Adherence to highly active antiretroviral therapy in the homeless population in San Francisco: a prospective study. *Clinical Infectious Diseases*. 2004;39:1190-1198.

16. Weeks MR, Li J, Dickson-Gomez J, et al. Outcomes of a peer HIV prevention program with injection drug and crack users: the Risk Avoidance Partnership. *Substance Use & Misuse*. 2009;44:253-281.

17. Leonard L, DeRubeis E, Pelude L, et al. "I inject less as I have easier access to pipes" Injecting,

and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed. *Int'l Journal of Drug Policy*. 2008; 19:255-264.

18. Sherman SG, German D, Cheng Y, et al. The evaluation of the JEWEL projects: An innovative economic enhancement and HIV prevention intervention study targeting drug using women involved in prostitution. *AIDS Care*. 2006;18:1-11.

19. Sterk CE, Theall KP, Elifson KW, et al. HIV risk reduction among African-American women who inject drugs: a randomized controlled trial. *AIDS and Behavior*. 2003;7:73-86.

20. Wechsberg WM, Lam WK, Zule WA, et al. Efficacy of a woman-focused intervention to reduce HIV risk and increase self-sufficiency among African American crack abusers. *American Journal of Public Health*. 2004;94:1165-1173.

21. National Institute on Drug Abuse. Research Report Series. Cocaine: Abuse and Addiction. May 2009. www.drugabuse.gov/PDF/RRcocaine.pdf

22. Sentencing. Stiff sentence for HIV+ crack user affirmed on appeal. *AIDS Policy & Law*. 2007;22:8.

23. Emery T. Will crack-cocaine sentencing reform help current cons? *Time Magazine*. August 7, 2009. www.time.com/time/nation/article/0,8599,1915131,00.html

24. Schlabig Williams J. Researchers adapt HIV risk prevention program for African-American women. *NIDA Notes*. April 2004. www.drugabuse.gov/NIDA_notes/NNvol19N1/Researchers.html

25. MacMaster SA. Social service delivery preferences among African American women who use crack cocaine: What women say they need before they can be open to HIV prevention services? *Journal of HIV/AIDS & Social Services*. 2006;5:161-179.

Special thanks to the following reviewers of this Fact Sheet: Susan Boyd, Michael Campsmith, Judith Cook, Tom Donohoe, Waleska Maldonado, Lisa Metsch, Kate Shannon, Steve Shoptaw, Claire Sterk, Bill Stewart, Tanya Telfair Sharpe.

Reproduction of this text is encouraged; however, copies may not be sold, and the University of California San Francisco should be cited as the source. Fact Sheets are also available in Spanish. To receive Fact Sheets via e-mail, send an e-mail to listserv@listserv.ucsf.edu with the message "subscribe CAPSFS first name last name." ©December 2009, University of CA. Comments and questions about this Fact Sheet may be e-mailed to CAPS.Web@ucsf.edu.