

HIV/AIDS Prevention Needs in African American Communities: A Sociological Research Observation from Alabama Belt

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Received: July 29 2025

Published: September 02, 2025

While many individuals, community organizations, and government programs have worked hard to address HIV/AIDS prevention needs of communities of color, based on over 20 years of sociological research in rural Alabama, several specific shortcomings can be found in much current HIV prevention efforts. The purpose of this commentary is to address the prominent shortcomings of existing efforts to prevent HIV/AIDS in Black Communities.

An understanding of the prospect for Alabama's Black Belt in the future requires that we take stock of the current situation and venture into the realm of futurism. Neither the current situation nor the future is transparent, and there is no assurance that even a thorough-going appraisal of either will reveal the secrets we seek. Still, questions about the prevention of HIV/AIDS in Alabama's Black Belt and the future of the region are compelling to those who study and care about the well-being of people in the changing countryside. What are the causes of enduring HIV/AIDS infection in Alabama's Black Belt? A search for answers is what we must undertake if, working in the footsteps of founders of the applied science of rural sociology, we would seek to contribute to the solution of HIV in the south.

Alabama's Black Belt

Alabama's Black Belt, the site for this study, is an ideal case for research examining the prevalence and severity of HIV in rural southern areas of the United States. The region is identifiable by the concentration of black people that inhabits it. It is a desperately poor place—among the poorest places in the United States. It is home to persistent poverty, poor employment, unemployment, limited education, poor health, single parenthood, and heavy dependence on public assistance programs (Zekeri, 2026; 2018). The residents are, as the President's National Advisory Commission on Rural Poverty put it in 1967, "people left behind." In 2025, it is still a place left behind in many respects. The poverty—stricken character of the area contrasts sharply with the affluence of white society. Majority of the counties in the area are among those counties categorized by the USDA as counties of "persistent poverty." The intent of the Johnson's Administration's Great Society

program "to eliminate the paradox of poverty in the midst of Plenty," continues to remain a paradox in Alabama's Black Belt Counties.

The idea that AIDS was created as part of a government-led conspiracy to decimate the African American population remains important to some black people in the area. Those who are HIV-positive still hold some conspiracy beliefs despite the factual information about HIV from different sources that are trustworthy. There is a research need to look into HIV conspiracy beliefs because such beliefs may have implications for HIV/AIDS surveillance, public policy, and prevention programs.

The purpose of this commentary is to review the persistent, agonizing problem of HIV, and suggest an approach that could be taken to turn the HIV crisis into a new era of community development in Alabama's Black Belt. It is important to understand the causes if the problem is to be solved.

The prominent shortcomings of existing efforts to prevent HIV/AIDS in Black Communities are:

1. Failure to concentrate prevention efforts and resources in the subgroups with the highest rates of infection (e.g., minority drug injection users and men who have sex with other men).
2. Failure to focus attention on the development of prevention strategies on recognition that individual behavior is a product of social influences and not just individual intentions.
3. Failure to focus on health insurance. One of the many reasons given is lack of health insurance. Most of the people interviewed believe that lack of health insurance by African Americans explains a significant part of the shortcoming.
4. Failure to aggressively seek and identify highly at risk hidden subgroups (e.g., African American transvestites who exchange sex for money or drugs).
5. Failure to direct adequate resources to the development of specialized HIV/AIDS prevention models targeted to social groups with shared social identities and subcultures that do not constitute distinct exposure groups.

6. Failure to prioritize the development of prevention targeted to unique patterns of risk in certain population (e.g., condom avoidance among black women because of the association of condoms with socially devalued relationships).
7. Failure in secondary prevention efforts (among those already infected).
8. Failure to address fully the issue of indirect sharing as a risk behavior.
9. Failure to address financial constraints and Poverty.
10. Inadequate Sex Education.
11. Stigma and misperceptions about HIV.
10. Lack of Trust in White Medical Health Professionals.
11. Lack of transportation
12. Failure to address food insecurity

Toward New Approaches to HIV/AIDS Prevention in African American Communities

As we move deeper into the decades of the AIDS epidemic, it is critical that we take stock of the lessons learned thus far in the prevention of HIV/AIDS in black communities and what can be done to improve. Recommended intervention efforts are:

- Community residents can be trained to be effective HIV peer educators; peer influence is a strong factor in risk reduction and the decision to be HIV tested.
- Prevention efforts must address the range of problems faced by target populations (and not just AIDS) if HIV prevention is to be effective.
- Sex education to reduce sex risk decreases among individuals who have friends who practice safer sex and who have someone to talk to about risk reduction.
- Intervention programs need to be regularly available, continuously visible to the target population, and generally accessible in order to retain high levels of participation.
- Involving individuals in HIV prevention efforts in their community, such as distributing prevention materials (e.g., condoms), is an effective approach for motivation to reduction in personal risk.
- High-risk individuals prefer role models who are most like themselves to deliver AIDS prevention messages.
- Community originated prevention efforts should be adopted.
- Pay attention to Stigma and misperceptions about HIV.
- Pay attention lack of Trust in White Medical Health Professionals.
- Pay attention to Lack of transportation.
- Devote more attention to addressing food insecurity.

Critical to social prevention is a refocus on the community as

a unit for intensive, systematic HIV/AIDS prevention education. Community level prevention can be adjusted to fit local context factors that shape risk patterns, such as the local unemployment rate, drug consumption patterns, presence of shooting galleries or prostitution stroll areas, or local ordinances that inhibit risk reduction. Community efforts should involve the participation of local indigenous community-based organization and coalitions. Community based efforts should be staffed by individuals who reflect the social composition of local neighborhoods. Community organization are able to bring into play a full awareness of local problems and conditions.

Conclusion

Efforts should actively engage local residents and community leaders in prevention planning and as peer educators and distributors of prevention materials.

Financial stability undergirds every other social determinant of health and determines the level of access to quality of the services an individual receives.

Lack of transportation coupled with poor public transportation infrastructure leaves many individuals unable to reliably attend crucial healthcare appointments.

Many of the Black Belt citizens live in food deserts without access to fresh, nutritious food options. Food security is fundamental to good health, and an individual who is busy figuring out his next meal has less time and energy to focus on staying well.

Healthcare access depends greatly on health insurance coverage. Secure coverage for Alabamians living with HIV, ending the epidemic will require insurance coverage for all.

We make a compelling case for community empowerment that is urgent and pragmatic.

*Based on focus groups and interviews with participants from the countries, the voices of affected individuals add depth and authenticity to the commentary.

References

1. Zekeri Andrew A. Issues and Challenges of the American Rural South. 3rd Revised Edition, Cognella Academic Publishing, 2026.
2. Zekeri Andrew A. "Racial- ethnic disparities in HIV/AIDS and health care in the United States: evidence from a sociological field research in Alabama's Black Belt." *Journal of Healthcare, Science and the Humanities*, 2018; 8(2): 31-44.