

THE DEEP SOUTH: A BLACK MAN'S EXPERIENCE IN BLACK BELT ALABAMA

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This narrative is a reflection on the life experiences of a southern Black man residing in the Black Belt region of Alabama. Through this process of sharing his experiences, the authors make visible the oppression and marginality experienced by many Alabamians. Possible survival strategies are explored and proposed. The authors believe these proposed strategies will enable southern Black Americans the opportunity to engage in community action.



Hubert Brandon and Coretta Scott King,
Selma, Alabama

Introduction

This narrative arose out of a great need for the first author, Hubert Brandon, to articulate and share his reflections working and residing in the Black Belt region of Alabama. By reflecting on and giving voice to his experiences, he is able to shed light on the persistent issues that southern Black Americans continue to face today. His experiences with challenges and struggles come at a time when the overall health profile of southern Black Americans presents a striking socioeconomic disparity.

We share these insights to create awareness of the critical issues facing southern Black Americans. Social justice perspectives are used to analyze these contextual settings. Sharing Mr. Brandon's story has provided an opportunity to identify

strategies needed to address the plight of poor southern Black Americans in Alabama. Our aim is to give voice so we can engage the process of community action and challenge systemic oppressive conditions of poverty which threaten the survival of southern Black Americans.

Profiling Alabama

Rural areas frequently pose different and, in some instances, greater challenges than urban areas in addressing a number of health issues (Lipscomb, Argue, McDonald, Dement, et al., 2005). The long-term economic struggles, the critical shortage of health care practitioners, and the inadequate number of rural emergency medical services are just a few documented challenges (Zuniga, Buchanan, & Chakravorty, 2005). Agricultural and recreational accidents occur with much greater frequency in rural areas where such activity abounds. The time required in transporting rural residents needing medical attention from their residences or from the scenes of accidents to adequate medical services is increased because of greater distance to be covered, greater reliance upon volunteers, and inadequate medical equipment.

Of Alabama's sixty-seven counties, twenty-two comprise the Metropolitan Statistical Area region, as designated by the U.S. Office of Management and Budget, and the remaining forty-five are rural. One of the rural regions of Alabama being studied in various ways nationally and locally is the Black Belt. The Black Belt is a vast stretch of

farmland extending from Georgia through Alabama and Mississippi. The specific counties in Alabama that make up the Black Belt is dependent upon who is defining the term. For this article, the Black Belt is defined as Bullock, Choctaw, Dallas, Greene, Hale, Lowndes, Macon, Marengo, Perry, Pickens, Sumter, and Wilcox Counties. This designation, historically equated with Dr. Booker T. Washington, maintains the integrity of the classical definitions based on the vast stretch of fertile, dark soil farmland conducive to cotton farming. While the soil color gave the region its name, historically, Black Americans have predominantly populated the counties that make up this area. The Alabama Black Belt is noted for the central role it played during the period in history when the economy of the south was based on cotton production by slaves, and later for its pivotal role in the civil rights movement of the 1960s. The Black Belt is contiguous with the Mississippi Delta, and this region is generally regarded as a "Third World Nation" in the heartland of America.

For decades, the Black Belt region of Alabama has been an area of paradoxes. The Cretaceous Period oceans that lapped over the area millions of years ago deposited some of the richest soil on Earth. But sadly for the region's residents, geological riches do not translate to economic wealth. Recent Census Bureau poverty statistics show no improvement. The numbers show that Alabama's statewide average of persons living in poverty (as defined by the federal government, an annual income of \$18,850 for a four-person family) is 15.4%; Lowndes County's average was 24%; Dallas County came in at 25%, and Perry County, a disheartening 32.3 %.

Selma is located in the heart of the Alabama Black Belt. Selma is generally regarded as the capitol of the Black Belt and is known to the world for its role in the civil rights struggle of the 1960s. Located in Dallas County, which has a median income of \$12,000. The population of Selma has a Black American population approaching 70%, approximately 50% of which live below the federal poverty level. Wilcox County, the state's poorest Black Belt County, reports

nearly 40% of the county's residents living below the poverty level, with 47% of the county's children living in poverty. In comparison, Selby County has a poverty rate of 6.3%. The U.S. Census Bureau (2000) state Alabama's poverty rate was the eighth highest in the nation with more than 754,000 Alabamians in poverty.

With regards to HIV and AIDS infection cases in Alabama, since February 2006, 5,982 HIV infections and 8,225 AIDS cases have been reported to the Alabama Department of Public Health, for a combined total of 14,207 reported HIV/AIDS cases in Alabama (Alabama Department of Public Health, 2006). Although Black Americans represent one-fourth (26%) of the state's population they account for two-thirds (62.9%) of its reported cases of HIV/AIDS. Black men represent 43.9% of all HIV/AIDS cases reported and Black women represent 19.1% of all HIV/AIDS cases reported (Alabama Department of Public Health, 2006). HIV/AIDS cases among Black Americans in Alabama are reported in the following risk factor categories: men who have sex with men (MSM) (32.5%), heterosexual (25.6%), injecting drug use-IDU (13.1%), MSM/IDU (5.0%), maternal transmission (0.9%), transfusion (0.5%), hemophilia (0.2%), and undetermined (22.0%). Age groups represented by HIV/AIDS in Black Americans in Alabama are staggering; with 31.1% between the ages of 20-29, 34.9% between 30-39, and 19.7 between the ages of 40-49. In addition, 10 of America's 100 poorest counties are in Alabama (Alabama Department of Public Health, 2006). These counties include: Wilcox, Perry, Green, Sumter, Macon, Lowndes, Bullock, Dallas, Conecuh, and Hale.

Other than its largest city (Birmingham), the area most affected by HIV/AIDS in the state of Alabama is its rural region. More specifically, the rural region with the highest HIV/AIDS rates is the Alabama Black Belt. Following Birmingham, the next highest concentration of Black American cases of HIV/AIDS in Alabama, is located in the Public Health Area (PHA) that encompasses the Black Belt region (20% of the population in PHA 8). In fact, almost 30% of the African

American cases of HIV/AIDS in Alabama are located in the Black Belt counties (Alabama Department of Public Health, 2006; Center for Disease Control and Prevention, 2004a). In addition, most ethnic minorities in Alabama and beyond are unaware of their risk for HIV/AIDS, high blood pressure, heart disease, stroke, cancer, diabetes, and infant mortality (Fullilove, 2006; Anderson & Smith, 2005; McKinney, 2002).

These issues have relegated southern Black people to live in the margins. As a resident, advocate and a community practitioner in Alabama, the first author is placed at the very core of this marginality. As a Black man working to actively advocate and challenge systemic oppression with his community, he is engaged in a process that challenges his own marginality.

Drawing on Relevant Social Justice Perspectives

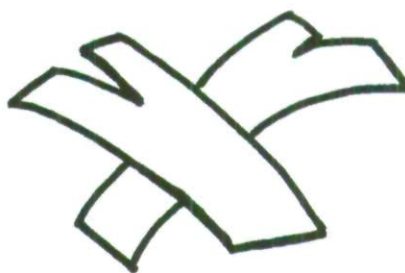
Our analyses have been informed by social justice perspectives (Rawls, 1971, Friere, 1972; Biko, 1978; hooks, 1984; West, 1993). These scholars have advocated the importance of understanding systemic oppression by examining the personal, contextual and structural factors of power and lived experiences. It is the perspective of social justice that helps to examine power, life events and how these events interact within the social environment. These ideas and theoretical underpinnings are informed by disciplines of psychology, sociology, feminism, political science, history, and African studies.

The concept of power is a useful framework to make sense of the social environment and to understand how power is used in every day interaction (Foucault, 1980). Power is everywhere; it is either real or perceived, but it has the ability to change people's lives (Foucault, 1980). Understanding how power is gained, received, and lost is central to our personal lives and how social identities are created.

The personal and social identity framework highlights the strong link between physical experience and psychological consciousness that shape the lives of Black Americans (Biko, 1978). For many Black

Americans, their personal narratives must be placed within a wider social context. Black Americans are not gifted the luxury to separate their life events from wider social problems because these two domains are intricately connected (Biko, 1978; Burke, Cropper, & Philomena, 2000).

Solidarity is a process where Black Americans begin to lead the movement for Black liberation (Biko, 1978). It is the process where Black Americans participate in the struggle by fighting for structural changes. Solidarity is joining together and uniting power that captures the essence that Blackness matters and must be valued.



Personal Reflections: The Author Comes to Terms with his Social Identity

For many Black Americans, their personal narratives are shaped by the social environment. These experiences take into consideration the nature of the power imbalance and the opportunity for solidarity within southern Black Americans. Given that this is Mr. Brandon's personal history, the remainder of this narrative will be told in his voice.

I was born and raised in a small town equidistant between Cleveland and Akron, Ohio. I grew up in a completely Black and segregated neighborhood, and attended an integrated school. My parents were both from Alabama and relocated to Ohio in the late 1940s to work in the steel industry. My family would always come to Selma to visit relatives during summer vacation until the year 1965 because of the civil rights unrest. I was twelve years old in 1965, and always wondered if my family had come that year what would we have

seen and whether we could have made a difference.

Fast forward to the year 1989. My parents had divorced, and my father returned to Selma to take care of his aunt who had raised him from the time he was two years old, after his own mother had died in 1914. "Aunt Abbie" was born in 1889, and was a remarkable woman who had been a nurse, school teacher, and community activist for years in the community. She was the daughter of former slaves, and one of a handful of Black registered voters in Selma. She was full of vigor and vitality: even beyond the age of 100. I came to Selma to help my father because my grandfather's health was failing and I wanted to put his affairs in order. During my two-month stay, I crossed the Edmund Pettus Bridge back and forth several times a day to attend to business. This bridge is the site of the "Bloody Sunday Massacre" that led to the passage of the 1965 Voting Rights Act.

One day I decided to get out of my car and walk in the footsteps of those marchers who had been beaten and trampled by horses on their way to Montgomery. As I walked across the bridge, I was overcome by an unseen and unheard spirit that brought tears to my eyes and filled my entire being. I heard voices that seemed to be telling me to do something with my life; to make a difference in what I can best describe as my "ancestral home." I could smell the tear gas that clouded the air thirty-five years earlier, and my lungs were choking as I seemingly gasped for air. The ghosts of the monumental civil rights battle in Selma were calling me, and changed my life forever.

I returned to Ohio, ran for public office, and over the next eight years transformed my own impoverished hometown by creating Enterprise Zones, which created over 10,000 jobs and 650 million dollars in capital investments and payroll. Even after those successes, my life still seemed hollow somehow as a result of my epiphany on the Edmund Pettus Bridge. I struggled for awhile, and returned to Selma in 1997 when my father became terminally ill. I promised my father on his death bed that I would take care of Aunt Abbie, who was now 107 years old. I thought

she could not last much longer, so I decided to stay until she died. I was still searching to find what it was I was being called to do and how I was to repay the debt I owed to the fallen soldiers of the civil rights movement. I became the primary caretaker for my aunt; she lived to be 112 years old, completely lucid and alert, and voted in every election until her death in 2001. It was her wisdom and knowledge of history that moved my career and life in a direction of working in the field of HIV/AIDS.

After her death I became involved in HIV/AIDS prevention, and will likely spend the rest of my life and career addressing this problem. Soon after entering this field, I was able to see clearly how the HIV/AIDS epidemic endangered poor ethnic minorities in the Deep South. Almost immediately I noticed that wherever I went in the state that I would be the only Black man in the room. This was puzzling because the overwhelming majority of the consumers of HIV/AIDS services were Black, and all of the Executive Directors of the AIDS Service organizations were White. Most of the funding not controlled by the state, but rested in the hands of people who did not live in the communities they served. When consumers would see me at meetings or presentations, they would cautiously approach me and, in hushed tones, inquire as to whether or not I was there to help them. It was an eerie feeling to have to speak with people as if we should not be discussing these very important issues. I soon discovered that there was a great deal of dissatisfaction with the services being provided, the lack of culturally competent programs, and service providers to the Black population.

My political battles back in Ohio pale in comparison to what I have witnessed in the HIV field as a result of the "old guard" organizations attempting to hold onto the funding and power, even as the epidemic has shifted regions, race, and demographics. Nothing in my background has adequately prepared me for the struggle to wrest control of funding and policy decisions. I draw upon solutions that were first used during the zenith of the civil rights movement to uncover methods of intervention that still have relevance today. The Deep South is unique, and so are

the answers to a myriad of problems that exist within the bowels of rural Black America.

In my tenure as a southern Black community organizer in the field of HIV/AIDS prevention, I have learned that community participation and engagement is necessary for change to occur. The problems of adverse poverty and HIV exist in rural Black America not because there is no desire to change behavior, but these problems are due to structural forces that do not value certain ethnic and marginalized groups. I call upon service providers, activists, academics, and community residents to mobilize for social change (the way the Student Nonviolent Coordinating Committee in 1964 organized for social and economic justice), to develop an agenda that is rooted in community participation.

From my experience as a community activist, I have learned over time that the community ought to be engaged for any successful HIV intervention to occur (Minkler, 2002; McPhaul & Lipscomb, 2005). This approach is known as the "The Community Health Advisory Model," and has been cited in the community-based research literature (Israel, Checkoway, Shulz, & Zimmerman, 1994; Dennis & Neese, 2000; Minkler, 2002; O'Fallon & Deary, 2002;). It is based on a community-based health promotion model that identifies trusted individuals from the community who have a heart for helping others (hooks, 1984; West, 1993; Israel et al., 1994; Minkler, 2002). I have trained local consumers using the "Community Health Advisory Model" to increase not only their health knowledge, but also the community to prevent HIV transmission. My goal is to create forums where the community can identify barriers which prevent acceptance and adoption of HIV programs by the target population (West, 1993). Using the information obtained from the forums, I will gather a network of indigenous lay health workers to train, motivate, educate, and navigate poor ethnic minority men and women to optimally utilize programs that prevent transmission of HIV.

I have begun to see the benefits of community-based forums where doctors and community members freely exchange

information, ideas and attitudes about prevention, early detection, and treatment of HIV/AIDS, as well as issues about survival and loss. These forums allow for information transfer and exchange to occur, and most importantly, it provides opportunities for collaboration and solidarity. The intention behind the creation of these forums is to impact screening and early detection rates of HIV/AIDS, thus curtailing the racial mortality disparities that presently exist. From my experience, knowledge is power - and the development of adequate resources to provide community based organizations with the ability to reach out to leadership is critical to the empowerment and social justice interventions that are needed. The survival strategies that I have described can be adapted to a larger community health intervention in Alabama to address the plight of southern and rural Black Americans.

Summary

During my lifetime there have been several issues that have commanded the attention of the American landscape, and only one where there has been a clear victory. The Vietnam War was waged for decades with an unfavorable result. The War on Poverty in the 1960s and 1970s was an abject failure: more Black families are living in poverty today than a generation ago. The continuing War on Drugs and Drug Abuse is failing and shows little promise of justifying the billions of dollars spent on the effort. The current Iraqi Freedom conflict threatens to drag on for years to come. The Civil Rights Movement of the 1960s appears to be the only conflict where a clear victory was achieved. That war was initially waged in the Deep South, and it makes sense to duplicate the efforts of small community based groups working within their own communities to address the most pressing issues. Those civil rights models can be successfully utilized in an all out assault on HIV/AIDS if the people are given the resources necessary to engage the enemies. The enemies are inadequate funding, stigma, ignorance, poverty, lack of training, apathy, and indifference. AIDS is the consequence of these factors, and they all must be addressed in any

real effort to eradicate HIV/AIDS in our community (Dalton, 1989).

The battleground for this "New Civil Rights Movement" is once again centered in the Black Belt of Alabama and the Mississippi Delta region, and it is a battle that threatens the entire nation. I have seen Black Americans from all over the country returning to their roots here in the Deep South and bringing with them undiagnosed cases of HIV. Those most at-risk are afraid to submit to testing. The HIV epidemiological data discussed in this article are but a part of the whole picture of the crisis in Alabama. Our task is to come together, gather our power, and launch a new civil rights movement in the Black Belt: one which focuses on our survival in the HIV/AIDS pandemic in our midst.

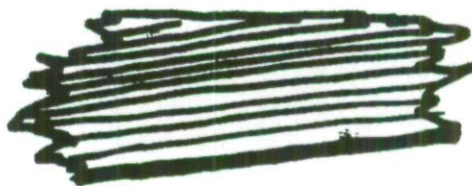
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