

**FROM SOIL TO STRUGGLE:**  
A Qualitative Study Of Health In Alabama's Black Belt

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**Jared Hirschfield**

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## INTRODUCTION

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On average, Blacks in the United States have poorer health than Whites.<sup>1</sup> Additionally, epidemiological research has established a rural health disadvantage in the U.S., with rural Americans maintaining significantly poorer health than Americans residing in urban or suburban areas.<sup>2</sup> While numerous articles and substantial resources have been dedicated to the study of each of these disparities independently, there has been a relative shortage of attention given to the health consequences resulting from the intersection of these identities—that is, Black and rural. Victim to the compounding impact of multiple oppressed identities, rural Blacks often suffer from an even greater health disadvantage than nonrural Blacks or non-Black urbanites. A genuine commitment must be established to further investigate this intersectionality and to seriously address the role it plays in propagating the profound health inequities from which millions of our most vulnerable citizens suffer.

Whereas most Blacks in the United States live in urban spaces, rural Blacks are quite geographically clustered. The South is home to over 90% of rural Blacks, most of whom reside in Black Belt counties.<sup>3</sup> The Black Belt was originally named for its dark, fertile, cotton-growing soil and was home to the vast majority of slaves in the United States. Today, the Black Belt represents a crescent-shaped

swath of Southern counties with a disproportionately high percentage of Black residents (usually over 40%). The poor socioeconomic conditions of the Black Belt, fueled by centuries of racism and institutional neglect, have translated into stark health inequities. Compared with the rest of the nation and, in some cases, even with rest of the South, rural Southern Blacks suffer from higher rates of mortality<sup>4,5,6</sup> and premature death,<sup>7</sup> and a lower life expectancy.<sup>8</sup>

In an attempt to draw much needed attention to the plight of these communities, this project employed a mixed-methods approach to study the etiology of the Black Belt's health disparities. Formal interviews of rural health and minority health stakeholders in Alabama were used to collect qualitative data. Quantitative analyses of ecological data from a variety of governmental and nonprofit sources were also conducted, the results of which will be published elsewhere. All qualitative findings from stakeholder interviews, as well as impressions informed by on-the-ground observations and interactions, have been organized in this report according to nine key themes.

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<sup>1</sup>Office of Minority Health (CDC). "Health Disparities Experienced by Black or African Americans --- United States," *Morbidity and Mortality Weekly Report* 54, no. 1 (2005): 1-3. <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5401a1.htm>. <sup>2</sup>Eberhardt, Mark, and Elsie Pamuk. "The Importance of Place of Residence: Examining Health in Rural and Nonrural Areas," *American Journal of Public Health* 94, no. 10 (2004): 1682-86. <https://doi.org/10.2105/AJPH.94.10.1682>. <sup>3</sup>James, Cara, Ramal Moonesinghe, Shondelle Wilson-Frederick, Jeffrey Hall, Ana Penman-Aguilar, and Karen Bouye. "Racial/Ethnic Health Disparities Among Rural Adults — United States, 2012-2015," *Morbidity and Mortality Weekly Report* 66, no. 23 (2017): 1-9. <https://www.cdc.gov/mmwr/volumes/66/ss/ss6623a1.htm>. <sup>4</sup>Cosman, Jeralynn, Wesley James, and Julia Kay Wolf. "The Differential Effects of Rural Health Care Access on Race-Specific Mortality," *SSM – Population Health* 3 (2017): 618-23. <https://doi.org/10.1016/j.ssmph.2017.07.013>. <sup>5</sup>Murray, Christopher, Sandeep Kulkarni, Catherine Michaud, Niels Tomijima, Maria Bulzacchelli, Terrell Iandiorio, and Majid Ezzati. "Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States," *PLOS Medicine* 3, no. 9 (2006): e260. <https://doi.org/10.1371/journal.pmed.0030260>. <sup>6</sup>Singh, Gopal, and Mohammad Siahpush. "Widening Rural-Urban Disparities in All-Cause Mortality and Mortality from Major Causes of Death in the USA, 1969-2009," *Journal of Urban Health* 91, no. 2 (2014): 272-92. <https://doi.org/10.1007/s11524-013-9847-2>. <sup>7</sup>Henning-Smith, Carrie, Ashley Hernandez, Marizen Ramirez, Rachel-Hardeman, and Katy Kozhimannil. "Dying Too Soon: County-level Disparities in Premature Death by Rurality, Race, and Ethnicity," University of Minnesota Rural Health Research Center Policy Brief (2019). [http://rhrc.umn.edu/wpcontent/files\\_mf/1552267547UMNpolicybriefPrematureDeath.pdf](http://rhrc.umn.edu/wpcontent/files_mf/1552267547UMNpolicybriefPrematureDeath.pdf). <sup>8</sup>Singh, Gopal, and Mohammad Siahpush. "Widening Rural-Urban Disparities in Life Expectancy, U.S., 1969-2009," *American Journal of Preventive Medicine* 46, no. 2 (2014): e19-e29. <https://doi.org/10.1016/j.amepre.2013.10.017>.

## METHODS

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Semi-structured elite interviews<sup>†</sup> were conducted to collect insights from rural health stakeholders who reside in the Black Belt or work extensively in Black Belt communities. Stakeholders meeting either classification were identified through web searches or through personal introduction by other interviewees. A total of forty-three introductory emails were sent to prospective interviewees. Twenty responses were received, and interviews were conducted with sixteen stakeholders. Evidently, interviewee selection involved convenient sampling and snowball sampling approaches, limiting the generalizability of the study's findings.

Interviews took place during a field visit to Alabama from June 5-13. All interviews were audio recorded, and most were subsequently transcribed and lightly edited for clarity. Casual visual and photographic observations of Black Belt communities (e.g. health care infrastructure,

local food options, housing availability and quality) were used to supplement the interviews and to “round out” the immersive experience.

The completion of all background research, travel, data collection, and data analysis took place during May and June of 2019 and was generously supported by a Northeastern University Summer Scholars Independent Research Fellowship grant. This project and its methods were approved by the Institutional Review Board (IRB) of Northeastern University.

This report is intended to provide a high-level overview of interview findings. Neither definitive conclusions nor causation of any sort can be drawn from the interviewees' insights.



**Bullock County Hospital**  
Union Springs, AL (pop. 3,465)

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<sup>†</sup> All interview questions can be found in the Appendix.

## INTERVIEWEES

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As with most social inequities, the causes of (and potential solutions to) health inequities in the Black Belt are astoundingly complex. To best address this complexity, the project aimed to collect insights from stakeholders with a diverse array of backgrounds, experiences, and occupations. Interviews were conducted with physicians, pharmacists, public health officials, nonprofit leaders, community organizers, academic researchers, and local politicians:

- **Albert Turner Jr., JD** (Perry County Commissioner, District 1)
- **April Golson** (Telehealth Program Manager, Alabama Department of Public Health)
- **Carrie Allison** (Director, Office of Performance Management, Alabama Department of Public Health)
- **Frances Ford, RN** (Executive Director, Sowing Seeds of Hope)
- **Jim Carnes** (Policy Director, Alabama Arise)
- **John Wheat, MD, MPH** (Director, Rural Scholars Program; Professor, University of Alabama College of Community Health Sciences)
- **John Zippert** (Greene County Community Organizer; Chair, Greene County Health System; Owner and Co-Publisher, Greene County Democrat)
- **Laurie Dill, MD, AAHIVS** (Medical Director, Medical Advocacy and Outreach)
- **Michael Murphree, LICSW** (Chief Executive Officer, Medical Advocacy and Outreach)
- **Monica L. Baskin, PhD** (Professor and Vice Chair for Culture and Diversity, University of Alabama at Birmingham School of Medicine; Associate Director for Community Outreach and Engagement, University of Alabama at Birmingham O'Neal Comprehensive Cancer Center)
- **Pilar Murphy, PharmD, BCACP** (Associate Professor of Pharmacy, Cardiovascular Risk Reduction Clinic, Sowing Seeds of Hope; Associate Professor, Samford University McWhorter School of Pharmacy)
- **Remona Peterson, MD, MS, MBA** (Medical Director, WEcare Family Practice Clinic; formerly Staff Physician, Greene County Health System)
- **Scott Harris, MD, MPH, FACP, FIDSA** (State Health Officer, Alabama Department of Public Health)
- **Sondra Reese** (Chronic Disease Epidemiologist, Alabama Department of Public Health)
- **Susan Youngblood**<sup>†</sup> (Selma Councilwoman, Ward 2)
- **Verna Keith, PhD**<sup>†</sup> (Professor and Chair, Department of Sociology, University of Alabama at Birmingham)

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<sup>†</sup> These interviews were conducted but not incorporated into this analysis.

## FINDINGS FROM THE FIELD

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### **Despite the progress achieved in the Civil Right Movements, many lament the persistence of a pervasive culture of racism and segregation in the Black Belt.**

Racism—the type of racism typically associated with a time well before the Civil Rights Movement of the 1950’s and 1960’s—is alive and well in the Black Belt. Of course, like anywhere else in this nation, the Black Belt grapples with intractable issues of implicit racial bias and the more silent, but no-less-lethal impact of institutional racism. What makes this region particularly unique, however, is the propagation of a unabashedly racist ideology many Americans believe to survive today only in history textbooks.

Interviewees unanimously emphasized the relative lack of change in race relations in the Black Belt over the last five decades. Albert Turner Jr., a Perry County Commissioner, emphasized the persistence of segregation in his community of Marion, AL: “Segregation is the same today as it was fifty years ago. You’re still segregated. You’re segregated in housing. You’re segregated in church. You’re segregated socially, educationally. Every

aspect of your life is a separation.” While the signs that once segregated restaurants, water fountains, building entrances, and waiting rooms were removed decades ago, for Black residents of the Black Belt those dividing lines are still very much visible. Jim Carnes, the Policy Director of the statewide nonprofit organization Alabama Arise, noted: “You may have White people and Black people living on the same block, but it’s almost like there’s an invisible separation. These people might be cordial to each other in their encounters, but there’s a distinction. . . . It’s really like going back in time.” A Black physician who grew up in the small Black Belt town of Thomaston, Alabama, Dr. Remona Peterson distinctly remembers experiencing this “invisible separation” throughout her childhood: “We lived in the center of town, which is a mixed neighborhood. I know our neighbors were White. Did we play together? No. We tried to invite them over once or twice. They didn’t come.”

**“Every aspect of your life is a separation.”**



### **Choctaw General Hospital**

Butler, AL (pop. 1,739)

Interviewees remarked that beyond being grossly unjust, pervasive segregation and discrimination in the Black Belt likely take their toll on the health of Black residents. In her work promoting preventive medicine in Black Belt and Mississippi Delta communities, Dr. Monica Baskin has seen the grave, long-term consequences of living in such a race-conscious environment: “I do think that the vestiges of slavery and the vestiges of Jim Crow weigh people down. . . . It’s the everyday little nicks and cuts that build up over a lifetime that really do play a role.” Interviewees suggested that chronic lifetime exposure to racism, manifested as overtly as derogatory racial epithets or as subtly as unintentional microaggressions, can at least partially explain poorer health outcomes among Blacks, including those in the Black Belt. This assertion is widely supported by empirical academic studies that demonstrate the deleterious impact of race on the mental and physical health of racial minorities.<sup>9</sup>

Interviewees also suggested that racism impacts health by promoting differential opportunity. By maintaining exclusive access to certain resources, Whites in Black Belt communities have deprived Blacks of an equal opportunity to achieve good health. Dr. Baskin recalled speaking with a Black resident about the construction of a new baseball field in the community. While excited about the prospect of a new field, a resource that would provide

residents with a venue for healthy physical activity, the resident told her that Blacks weren’t allowed to use the field. Dr. Baskin explained: “Whereas legally that’s not the case—I mean we know there’s nothing on the books that says Blacks cannot utilize that field—the de facto and the historical and social viewpoint . . . was that it still wasn’t accessible to that population. Sometimes even when it’s legally no longer on the books, the culture and the traditions are still kept up.” Similar stories were reflected in other interviews. Dr. Peterson mentioned a pool in her hometown of Thomaston in which “no Black person has ever swam,” as White residents maintain that “you have to be a part of a [certain] group or organization to swim in the pool.” The unequal distribution of resources and access to resources naturally contributes to the drastic racial health disparities plaguing Black Belt communities. Dr. Baskin concluded: “Being cut off from the better grocery stores or from the better parks and recreational facilities has a direct impact on health. . . . Certain communities tend to get the potholes filled and the drains emptied out, and other communities don’t.” In the Black Belt, the communities on the underserved side of that coin tend to be those that are predominantly Black.

<sup>9</sup>Paradies, Yin, Jehonathan Ben, Nida Denson, Amanuel Elias, Naomi Priest, Alex Pieterse, Arpana Gupta, Margaret Kelaher, and Gilbert Gee. “Racism as a Determinant of Health: A Systemic Review and Meta-Analysis,” *PLOS ONE* 10, no. 9 (2015): e0138511. <https://doi.org/10.1371/journal.pone.0138511>.

While it may be tempting to explain the poor health outcomes of the Black Belt by pointing to the poor health outcomes of Blacks nationwide, interviewees pointed out that the story of race in the Black Belt would be wholly incomplete without an acknowledgement of the strong legacy of slavery in the region. Mr. Carnes put it this way: “The Black Belt’s demographic makeup is not the result of settlement patterns or migration over time. It’s the imprint of enslavement.” The Black Belt is largely synonymous with the Plantation South. That the region’s dark, loamy soil is well-suited for cotton growing and that the region is today disproportionately Black is in no way a coincidence. Interviewees stressed that the current state of health in the Black Belt must be viewed through a historical lens and with an understanding that the plight of Blacks in the region today is a direct product of the institution of slavery. Michael Murphree, the CEO of Medical Advocacy and Outreach, an organization providing comprehensive care for Alabamians with HIV/AIDS and other life-threatening illnesses, described the connection between Alabama’s past and present:

“The plantation mentality was always you keep a poor, undereducated population because then you get a cheap labor force. Now, Alabama is suffering from that legacy.”

When asked if they thought today’s Black Belt health disparities represented a consequence of White apathy toward the struggles of Black residents, many interviewees asserted that the disparities were fueled by much more than indifference. Mr. Turner responded: “It’s more than an effort to maintain the status quo. It’s an effort to suppress.”

Interviewees saw the region’s health inequities as products

**“It’s more than an effort to maintain the status quo. It’s an effort to suppress.”**

of the many measures White legislators have taken to actively stifle the development of Black communities. Mr. Carnes and others referenced the state’s preemption of Birmingham’s increased minimum wage in 2016 as a clear example of such measures, citing Birmingham’s majority Black population as the perceived motivation for the legislature’s action.<sup>10</sup> It seems the remnants of this



**Crenshaw Community Hospital**

Luverne, AL (pop. 2,751)

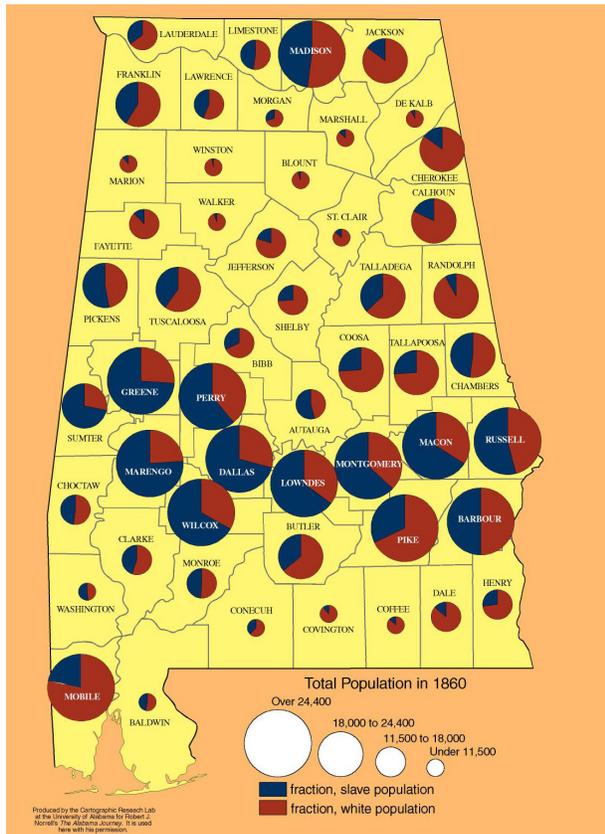
<sup>10</sup>Roth, Zachary. “Birmingham Raises Minimum Wage and Alabama Takes It Away,” NBC News, last modified February 26, 2016. <https://www.nbcnews.com/news/nbcblk/birmingham-raises-minimum-wage-alabama-takes-it-away-n526806>.



**Family Health Clinic of Union Springs**

Union Springs, AL (pop. 3,465)

plantation mentality are used to keep things how they've always been: unfair. Dr. Baskin commented on some of the policies (or lack of policy) that have facilitated the suppression of Black Alabamians: "The system is set up for those people who have to continue to have and for those people who do not have to continue not to have. That's where I think the lack of expanding Medicaid, the issues around employment or crazy requirements for people who get public assistance (work requirements, drug screenings) play a role. The power structure is very much in control and wants to go back to the days in which people felt like they had the height of power."



Alabama Census of 1860: Percentage of Enslaved Residents by County

11

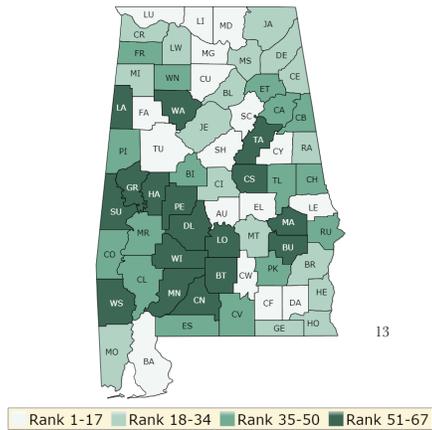
There is discussion in the sociological literature of the impact of legacy on Blacks in the South—a legacy of slavery and Jim Crow and centuries of overt, organized oppression—but perhaps nothing is more telling than the map of Alabama’s 1860 census. Several interviewees referenced this map depicting the percentage of enslaved residents in each of Alabama’s 67 counties in an attempt to explain the relationship between the legacy of slavery and the current state of health in the Black Belt. Dr. Scott Harris, the State Health Officer and top official of the Alabama Department of Public Health, asserted that he only needs this one map to explain Alabama’s health disparities: “The way I use this map is to show what the health disparities in our state are. What

Black Belt Counties of Alabama



12

Alabama Counties Ranked by Health Outcomes



13

are cervical cancer rates by county? What are cardiovascular disease rates by county? You name it, pick a condition. . . . This 1860 Alabama census is the public health map of 2019. It’s the same map. It hasn’t changed.” Plagued by racist policies and social norms, Blacks in the South remain heavily suppressed over 150 years after the abolition of slavery. It seems clear that poor health outcomes in the Black Belt represent a product of the broader tragedy of broken promises in the South.

**“This 1860 Alabama census is the public health map of 2019. It’s the same map. It hasn’t changed.”**

<sup>11</sup>“Total Population in 1860,” Alabama Maps, University of Alabama Department of Geography. <http://alabamamaps.ua.edu>. <sup>12</sup>“Alabama Black Belt,” Wikipedia. <https://upload.wikimedia.org/wikipedia/commons/2/21/AlabamaBlackBelt.png>. <sup>13</sup>“2019 Alabama Health Outcomes Map,” County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute. <https://www.countyhealthrankings.org/sites/default/files/state/downloads/2019%20Health%20Outcomes%20-%20Alabama.png>.



### **Georgiana Medical Center**

Georgiana, AL (pop. 1,616)

### **Inequity in Alabama’s education system is often viewed as the most visible manifestation of institutional racism.**

The Supreme Court’s 1954 ruling in *Brown v. Board of Education* deemed segregation in public schools illegal. What it did not do, however, was assertively require complete school integration. Arguably, nowhere else in the country is this chasm between the law and reality larger than in the Black Belt. Today, schools in Alabama’s Black Belt are starkly segregated by race, with predominantly Black schools receiving fewer resources and achieving worse outcomes.<sup>14,15</sup>

According to John Zippert, a community organizer, hospital system chair, and newspaper owner in Greene County, when it comes to schools, “things are kept segregated and separated.” White residents keep their children isolated from Black children by sending them to predominantly White public schools or, more commonly, to White private or charter schools—referred to by interviewees as “white flight academies” or “segregation academies.” With the lion’s share of state education funding flowing into these White public and charter schools, the amount of funding

earmarked for the Black schools is simply insufficient. Dr. Baskin commented on the effects of school segregation, consequences that extend beyond the obvious educational deprivation: “There are still many school systems in the Black Belt that have higher concentrations of Blacks. Those schools tend to be older and don’t have the same types of educational experiences, whether that’s equipment or books or so forth. There’s also the psychology of it. Those kids get hand-me-downs from the other schools systems, and there’s a psychology of that community not being worthy of things that are new or things that are modern, things that are really nice that everybody wants.”

Interviewees were confident in saying that segregated schools and school funding inequities contribute significantly to poor health outcomes in the Black Belt. As Mr. Carnes argued, school funding inequities fuel inequities of many other types, including income disparities and, consequently, health disparities: “School funding inequities are probably the most blatant example of racism. I don’t think you can argue that educational disparities don’t play a significant role in propagating opportunity disparities and economic disparities in these communities. Alabama has simply not faced up

<sup>14</sup>Farzan, Antonia Noori. “Sumter County, Ala., Just Got Its First Integrated School. Yes, in 2018,” *Washington Post*, last modified August 15, 2018. [https://www.washingtonpost.com/news/morning-mix/wp/2018/08/15/sumtercounty-ala-just-got-its-first-integrated-school-yes-in-2018/?utm\\_term=.8eb551ec590f](https://www.washingtonpost.com/news/morning-mix/wp/2018/08/15/sumtercounty-ala-just-got-its-first-integrated-school-yes-in-2018/?utm_term=.8eb551ec590f). <sup>15</sup>Harvey, Gordon. “Public Education in Alabama After Desegregation,” *Encyclopedia of Alabama*, last modified December 18, 2018. <http://www.encyclopediaofalabama.org/article/h-3421>.



**Gilberttown Medical & Dental Center**

Gilberttown, AL (pop. 197)

to the racial inequities in school funding.” According to interviewees, these funding inequities stem in large part from Alabama’s peculiar restrictions surrounding school funding. Under the state’s 1901 Constitution, local governments face substantial barriers to raising property taxes for support of public schools, a restriction many interviewees saw as a vestige of an outdated legal system biased toward the interests of the White, landowning elite. Dr. Laurie Dill, the Medical Director of Medical Advocacy and Outreach, suggested that considering Alabama’s history of racism, there should be nothing surprising about the state of segregation in the state’s school system or the state’s dismal educational outcomes: “Alabama schools are functioning exactly how they were designed to function. It was based on race, and we’re still living with that.”

Educational disparities present an especially difficult challenge considering their long-range impact. The benefit of a quality education lasts a lifetime, but unfortunately so does the damage of a poor one. Interviewees suggested that a comprehensive plan to alleviate economic and health disparities in the Black Belt must aim to address school segregation and school funding inequities as a means to empower younger generations.

**Alabama’s failure to expand Medicaid is widely cited as a primary contributor to the state’s health disparities and generally poor health outcomes.**

Interviewees characterized Alabama’s failure to expand Medicaid under the Affordable Care Act as “deadly,” “devastating,” and “a travesty.” Considering Alabama’s Medicaid eligibility requirements, it is not difficult to see why. While requirements for children and pregnant mothers are relatively generous, requirements for non-parent adults are astoundingly stringent. In fact, as it stands, no able-bodied, non-parent adults in Alabama, regardless of income, are eligible for Medicaid.

Interviewees saw in the ACA’s proposed Medicaid expansion an opportunity to extend access to care to the state’s many poor, uninsured adults and to offer reprieve to Alabama’s struggling rural hospitals. None of this, of course, has been possible under the Republican-led Alabama legislature. Dr. Baskin confirmed that the benefits enjoyed by expansion states, namely lower

uninsurance rates, have not been seen in Alabama: “We still have a large percentage of people who are uninsured or underinsured and that, combined with a lack of access to providers, is a deadly kind of scenario.” Many interviewees suggested that the legislature’s inaction was a moral failing, and some went as far as to deem it a religious failing. Frances Ford, the Executive Director of Sowing Seeds of Hope, a nonprofit serving low-income residents of Perry County, explained her disapproval in faith-based terms: “It puzzles me because we’re in the Bible Belt, and God commands that we are there to help those that are in need, to care for the least of these, to visit those that are sick. . . . It puzzles me as to why in a state where we all speak about how we are so religious and how our faith is so important to us, we are not doing the things that we have been mandated to do.”

Interviewees offered several explanations for the state’s refusal to expand. Some suggested that partisan politics were the primary factor at play and that the Republican state legislature railed against Medicaid expansion because it represented the legacy of President Obama and



**Greene County Hospital**  
Eutaw, AL (pop. 2,652)



**Hale County Hospital**  
Greensboro, AL (pop. 2,291)

the Democrats. Others identified institutional racism as the root cause, citing a fear of Black advancement among some White citizens and legislators and a desire to keep Black Alabamians suppressed. Mr. Turner, for example, saw race as the principle influence: “The legislators believe that it’s hurting more Blacks than Whites. . . . You also have so many poor Whites who believe that if somehow you gave Medicaid to Black people, they would take their place in society. They would rather be poor and without insurance with hopes that they can make it than expand this program for everybody.”

Medicaid expansion is still a hot-button issue in Alabama, as health advocates have clashed for years with conservative politicians refusing to reverse their position. Mr. Zippert has already gone to jail twice protesting for Medicaid expansion—once for holding an afterhours prayer vigil in the Alabama State Capitol for the governor to change his mind and once for pouring ketchup on the Capitol’s statue of Jefferson Davis to symbolize the continuing bloodshed of this Confederate ideology. For Zippert, the politics are personal. As the chair of the Greene County Health System, Zippert is responsible for managing the finances of the System’s hospital, physician’s clinic, and nursing home, a task that is virtually impossible without Medicaid expansion. He explained that the Greene County Health System provides about \$100,000 a month in

uncompensated care, only \$45,000 of which is covered by a tax on county bingo machines implemented in late 2017. Zippert noted that Medicaid expansion, if implemented, would cover a significant portion of the hospital’s remaining monthly deficit. Other interviewees suggested that this is a story shared by almost all small, rural hospitals across the Black Belt, facilities that cannot stay afloat with such high uncompensated care costs constantly dragging them under.<sup>16</sup>

While interviewees unanimously recognized an immediate need for Medicaid expansion, some cautioned against viewing expansion alone as sufficient to effectively combating health inequities in the region. These interviewees emphasized the need to concurrently address other factors, such as health professional shortages and a lack of navigation assistance for social services. Dr. Baskin experienced firsthand the difficulties of navigating the bureaucracy of social services while helping patients enroll in Marketplace health insurance plans and stressed the need for Medicaid expansion to be accompanied by comprehensive support, if enacted in Alabama: “You absolutely have to have the navigation piece. You have to have the outreach and education to ensure people know what is available, and then you need the patient navigation piece to help walk them through how to access those resources.”

<sup>16</sup>Thornton, William. “Hospital Closing Highlights Problems of Rural Healthcare,” AL.com, last modified February 13, 2019. <https://www.al.com/business/2019/02/hospital-closing-highlights-problems-of-rural-healthcare.html>.



**Hill Hospital of York**

York, AL (pop. 2,267)

All interviews affirmed that Medicaid expansion would go a long way in improving health outcomes in the Black Belt by making medical care accessible for the region's most vulnerable residents. Some interviewees acknowledged the potential of Medicaid expansion to alleviate disparities typically placed well outside the reach of health care. Mr. Carnes, for instance, has been advocating for Medicaid expansion in the past few months as a solution

to Alabama's dreadfully overcrowded and failing prison system.<sup>17</sup> Whether for economic, moral, or political reasons, all interviewees demonstrated overwhelming support for Medicaid expansion and suggested the fight for Medicaid expansion in Alabama is far from over.

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<sup>17</sup>Carnes, Jim. "Medicaid Expansion Must Be Part of the Solution to Alabama's Prison Woes," The Anniston Star, last modified January 15, 2019. [https://www.annistonstar.com/opinion/jim-carnes-it-s-time-for-alabama-to-gobig/article\\_81ce96c8-2045-11e9-825c-472290b99ac3.html](https://www.annistonstar.com/opinion/jim-carnes-it-s-time-for-alabama-to-gobig/article_81ce96c8-2045-11e9-825c-472290b99ac3.html)



**L.V. Stabler Memorial Hospital**

Greenville, AL (pop. 7,553)

**The health care system in the Black Belt is not much of a system at all.**

A weekend drive through the Black Belt's small towns is all one needs to recognize that health care is sparse and worlds away from health care in urban centers like Boston. Considering the region's economic conditions and high uninsurance rate, it's not difficult to deduce why. Asked to characterize the health care ecosystem in the Black Belt, Mr. Carnes responded: "It's threadbare. It's chronically underfunded. . . . There are hospitals that are treading water barely. There are enormous factors that impinge on the health care system: inadequate housing, inadequate basic services like water and transportation, lack of internet access." Interviewees noted the importance of viewing the health care system in the context of the multitude of other socioeconomic, political, and behavioral factors that coexist alongside, and undoubtedly contribute to, the struggles of the health care system in the Black Belt.

In 2017, Dr. Peterson joined the Greene County Health System as a Staff Physician but, as she reported, was unprepared to handle the many challenges that come with working as a physician in a small, rural hospital. After a short while, the long hours, obstinate staff, and unbearable stress of practicing with little time and scant resources became too much to bear, and she moved to Tuscaloosa, where she has since opened a private practice. Peterson described the complexity of treating some of her patients in Greene County: "I wanted to help and I tried, but I had to be the social worker, I had to be the psychiatrist, I had to be a friend, everything. Some of these people couldn't read, and they were in their fifties and sixties. You have to spend so much extra time with these people. It's so difficult." She also recounted several stories in which she felt she could not treat her patients adequately with the resources available, struggling to find casting materials for a broken ankle or unexpired antibiotics to treat a sick child. This inability to provide care that was up to her



### **Pine Apple Health Center**

Pine Apple, AL (pop. 119)

standards is what set her over the edge: “I couldn’t take it. I couldn’t be there as a physician trying to help someone when I didn’t have what I needed to help them.” Reflecting on her experience in Greene County, Peterson was adamant that programs aiming to fill physician shortages must provide physicians with additional pre-placement training and post-placement support.

The shortcomings of the Black Belt’s health care system, and many of the issues Dr. Peterson faced, have their roots in the poor socioeconomic conditions of the region. Ineligible for Medicaid under the state’s stringent eligibility requirements and without money to pay for private insurance, many residents are uninsured. When these residents visit a hospital,

usually for a major injury or illness, the hospital is often left uncompensated for the care it provides, a phenomenon that has

forced many rural hospitals in the Black Belt to close and has placed most, if not all, of the remaining hospitals under serious financial duress.

While other non-hospital health facilities (i.e. Federally Qualified Health Centers and Rural Health Clinics) exist in the Black Belt to serve uninsured or underinsured individuals, interviewees noted that these facilities carry extremely high patient loads and are not always geographically convenient for patients without reliable transportation. This leaves many residents with little to no options for preventive care or acute care, especially with the recent rate of rural hospital closures in Alabama. Mr. Carnes summed up the state of the health care ecosystem in the Black Belt in this way: “Across the Black Belt you have people who have no health coverage, which means that they’re not formally connected with any piece of the health care system. They’re just kind of adrift. It’s a real challenge. . . . The health care system is disjointed. It’s either sparse or redundant. It makes no sense. There is no system.”

**“I couldn’t take it. I couldn’t be there as a physician trying to help someone when I didn’t have what I needed to help them.”**

**Poor health literacy and a distrust of medical professionals hinder the implementation and efficacy of medical interventions.**

Aside from a very tangible lack of adequate resources, there are also several intangible factors that complicate the provision of health care in the Black Belt. Poor health literacy and a strong distrust of medical professionals are dynamics faced regularly by health care providers in the region, both of which are the direct result of centuries of inequity and abuse.

In light of the aforementioned educational inequities and poor educational outcomes, it is not surprising that many Black Belt residents maintain low levels of health literacy. Health literacy poses a major downstream challenge for patients. After addressing financial and insurance-related concerns, locating transportation, and taking off of work, patients struggling or unable to understand medical instructions face yet another frustrating barrier to care. Dr. Pilar Murphy, a pharmacist at Sowing Seeds of Hope’s Cardiovascular Risk Reduction Clinic in Marion,

Alabama, explained how poor health literacy prevents some patients in the Black Belt from ever receiving care: “People don’t understand what the doctor is saying or they don’t understand how to fill out the forms. Some are too embarrassed to tell you that they don’t know how to fill out the forms, so instead of coming back, they just pretend they didn’t get your call.” Poor health literacy also impacts the efficacy of medical treatment. Several interviewees mentioned stories of patients who did not understand instructions for how to take prescribed medications. For example, Dr. Murphy told the story of a young man who was prescribed antibiotics and instructed to take them three times a day. During the follow-up visit, he reported confusion about whether “three times a day” meant that he should take all three doses in the morning. This additional challenge seems to underscore Dr. Peterson’s recommendation that health professionals practicing in rural Black Belt communities be specially trained to provide care to local residents.

A distrust and fear of medical professionals and the health care system also poses major challenges for patients and health care providers. The horrors of the Tuskegee syphilis



**J. Paul Jones Hospital**  
Camden, AL (pop. 1,819)



**Marion Health Center**

Marion, AL (pop. 3,252)

experiment (officially, The Tuskegee Study of Untreated Syphilis in the Negro Male) loom large in the minds of many Black residents in the Black Belt.<sup>†</sup> According to many interviewees, the Tuskegee experiment has naturally made Black residents seriously doubt that the health care system or its predominantly White health care professionals have their best interests at heart. Dr. Baskin confirmed this link: “There’s still, particularly among African Americans in this region of the country, some level of distrust about whether or not what they’re being told is in fact the reality or whether they’re being used as guinea pigs. . . . That is the legacy of Tuskegee and other types of things where you’re not getting accurate information.”

Almost all interviewees concluded that this hesitance to regularly engage with the health care system is a contributor to the poor health outcomes in the region. Several officials at the Alabama Department of Public Health (ADPH) recounted the challenges they encountered when trying to control a tuberculosis outbreak in the Black Belt several years ago.<sup>18</sup> Unable to convince Black residents with tuberculosis to come into the health department to receive free treatment, ADPH eventually began offering monetary incentives for infected individuals who decided

to make the trip. Even then, many individuals refused to come. The wariness of tuberculosis-infected residents to engage with the health care system certainly makes clear the tremendous difficulty of convincing healthy residents to receive preventive care, even if such care was more financially and geographically accessible. Of course, quality preventive care does wonders to prevent chronic diseases, so it is likely that this distrust helps to partially explain the high rates of chronic diseases, such as diabetes, in the Black Belt.

When asked to describe the origins of residents’ guardedness, Dr. Harris responded emphatically: “We’re the state with the Tuskegee syphilis study. We’re the state with Jim Crow laws. We’re the state that has systematically done nothing in a hundred and fifty years for the Black community, so of course there’s a lack of trust. That’s the least shocking thing ever.”

**“We’re the state that has systematically done nothing in a hundred and fifty years for the Black community, so of course there’s a lack of trust. That’s the least shocking thing ever.”**

<sup>†</sup>The Tuskegee syphilis experiment, which took place between 1932 and 1972 in Macon County, Alabama, enrolled hundreds of Black men and misled them to believe that they were simply receiving free medical treatment. Participants with syphilis were deprived adequate treatment for the disease, even after penicillin became the standard treatment for syphilis in 1947.

<sup>18</sup>Ouyang, Helen. “Where Health Care Won’t Go: A Tuberculosis Crisis in the Black Belt,” Harper’s Magazine, last modified June 2017. <https://harpers.org/archive/2017/06/where-health-care-wont-go/>. <sup>19</sup>“U.S. Public Health Service Syphilis Study at Tuskegee – The Tuskegee Timeline.” CDC, last modified December 22, 2015. <https://www.cdc.gov/tuskegee/timeline.htm>.



### **Hill Hospital Physicians Clinic**

York, AL (pop. 2,267)

**The impact of poverty (and related dynamics, such as lack of economic opportunity) lies at the heart of the region’s health disparities.**

The impact of deep-rooted poverty on the health of the Black Belt cannot be overemphasized. Practically all other factors fueling the health disparities in the region—uninsurance and underinsurance, lack of transportation, educational inequities—have, in some way, a foundation in poverty. Some interviewees noted that poverty remains a significant barrier to health even when controlling for other factors. Dr. Harris explained how money—or perhaps more aptly, a lack thereof—seems to lie at the root of many of the region’s health care challenges: “If you don’t have money, it’s difficult to obtain medical care, insurance or not.”

Poverty in the Black Belt is a story of its own, and an attempt to extensively outline the causes and products of Black Belt poverty is not made in this report. However, the lack of economic opportunity in the Black Belt, most directly manifested in a glaring shortage of reliable employment, is too central to the region’s narrative of poverty to be left out of the discussion. There are simply not enough jobs in the Black Belt, and the consequences of this certainly play out in health disparities. Dr. Peterson spoke to the benefits of expanding the job market, which, according to her,

would include better health services: “If you look across the Black Belt, there are no jobs. When you bring jobs to rural Alabama, these people get to have income. They get to have insurance. They can afford things for their families. There is a huge impact when you bring jobs. . . . If you put jobs in those communities, you bring doctors because you bring money.” Accordingly, programs that would create local jobs, such as public works initiatives and incentives to attract large corporations to the region, may help indirectly alleviate health inequities in the Black Belt.

The countless and terribly destructive tentacles of poverty reach virtually all aspects of residents’ lives. Many interviewees described how poverty is not so much a singular cause of poor health outcomes as the monolithic force driving all such causes. Mr. Zippert explained the multifactorial impact of poverty on Black Belt families: “You go to their home the third week of the month and you open their refrigerator. They might have a jar of peanut butter. They might have a few eggs left, one or two tomatoes (maybe if they have a garden), but that’s it. . . . In that home, there are probably very few books and very



**Pine Apple Health Center**

Pine Apple, AL (pop. 119)

few children’s books. So from the very beginning, you’re dooming the next generation. They’re not getting enough nutritious foods. They’re not getting exposure to things.” The health effects of inadequate and, in some cases, dangerous housing conditions—another direct product of poverty—were also referenced in several interviews.

**Despite its grave challenges, the Black Belt is home to tremendously resilient, socially cohesive, and religious communities.**

The Black Belt is certainly no stranger to struggle. Well-intentioned journalists and academic researchers often focus exclusively on this struggle, working to better understand the region’s challenges in order to better solve them. Unfortunately, the region’s gifts—the unique qualities that Black Belt communities bring to the table—are lost in that approach.

Almost all interviewees referenced the strong presence of resilience in the Black Belt, which many argued is a product of the historic discrimination faced by the Black population in the region. Mr. Zippert explained the source of this resilience: “The Black people in Alabama who are here today have survived a long history. In every category—health, criminal justice, housing—they’ve been subjected to problems and abuses. The people who are here today have survived all of that and deserve a lot of credit.” Dr. Baskin added that the Black experience over

the past several centuries has created a distinct narrative in the region: “I think that’s also the spirit of what’s here in the Black Belt, a resilience. In spite of all of the odds, to still be standing.” Interviewees had tremendous faith in the power and potential of Black Belt residents to overcome obstacles.

The people, Mrs. Ford stressed, are what make the Black Belt the vibrant and welcoming

**“They are resilient. They are creative. They are people that can live up to the challenge.”**

community it is: “They are resilient. They are creative. They are people that can live up to the challenge. . . . They’re working and struggling with a smile. You see the numbers, but what you need is to come and see the people. . . . Our greatest asset is our people, their willingness to work with others, to be receptive of new ideas.”

Many interviewees reflected on the close-knit nature of Black Belt communities. Dr. Dill noted: “What communities will do to support each other, what families will do to support each other is amazing.” Similarly,



**Rush Medical Group – Livingston**

Livingston, AL (pop. 3,364)



**Troy Regional Medical Center**

Troy, AL (pop. 19,126)

many interviewees reported that Black Belt residents generally feel supported by their family and friends. Some interviewees were doubtful, however, that this support and social cohesion yields the same protective effects in all counties. Dr. Harris, for example, offered this qualification: “I think a strong sense of pride in one’s community is present across many rural, small communities, but, to be fair, it doesn’t seem to help the people in Dallas County (a majority Black county in the Black Belt) the way it helps the people in other mostly White counties.” Without more targeted sociological research, it is difficult to definitively predict what impact, if any, social cohesion has on the health and well-being of Black Belt residents.

There is no shortage of churches in the Black Belt. While a commitment to religion is a well-recognized quality of the South generally, religion arguably plays an even more significant role in the Black Belt. Several interviewees argued that Black residents in particular have turned to their Christian faith as a form of protection from the

ongoing abuse that has plagued the region for centuries. Mr. Murphree explained: “Faith becomes even more of a survival strategy because your church is where you go to survive. Among the Black communities, church was the protective environment from what was systemically going on around them.” Some interviewees described how it is common in small Black Belt communities for churches to assume the role of the principle caretakers of the people, often in place of the state or federal governments. Dr. Baskin confirmed this function: “Churches have been very helpful in bridging the gap when there aren’t resources. People aren’t depending on someone else to come in.” For these reasons, future programs that closely engage with the faith-based community are likely to be more effective in reaching residents in the Black Belt.



**Vaughan Regional Medical Center**

Selma, AL (pop. 17,886)

**There is optimism that health disparities in the Black Belt will be alleviated, but not without heavy qualification.**

All but one interviewee reported feeling optimistic that health disparities in the region will be successfully addressed in the future. Most of these reports, however, were qualified in some way. Several interviewees felt confident

that there would be improvement in coming years but that it would be small; others made clear that they only foresaw improvement in the far future and not in the next several years.

**“It’s going to take cooperation from people who don’t cooperate with one another, who don’t necessarily like one another.”**

Dr. Harris expressed optimism but commented that any initiatives to truly eliminate these disparities must be proactive: “I’m optimistic that we can make a difference, but if you want to eliminate these health disparities, you need to start two years before the person is born.” Dr. Baskin also reported feeling optimistic but wanted to emphasize the massive political undertaking required to make strides in reducing the inequities: “I have to be optimistic that things are going to improve. Now what it’s going to take is something that is pretty huge. It’s going

to take cooperation from people who don’t typically cooperate with one another, who don’t necessarily like one another.”

Not all interviewees explained the rationale behind their optimism, but for those who did, it was almost always the growing acceptance of social determinants as legitimate determinants of health. These interviewees felt that several decades ago they could not speak as openly and as seriously about social determinants of health—such as race, housing, income, food security, etc.—and that the conversation has since grown to incorporate these factors into the public health calculus. Mr. Carnes saw this evolution in rhetoric not as the ultimate solution to health disparities in the Black Belt, but as a major first step in the right direction: “You can’t settle for changes in rhetoric or changes in conversation, but until the conversation changes the policies aren’t going to change.”

While there was clearly widespread optimism among interviewees that health disparities in the region would somehow be alleviated, there was not much optimism surrounding the prospect of securing genuine buy-in from state political leaders anytime soon. Many saw political will as the final missing piece of the puzzle and were thereby not entirely confident that the puzzle will ever be completed, at least not under the current Republican-led legislature.



#### **West Alabama Mental Health Center**

Butler, AL (pop. 1,739)

**Programs and initiatives aimed at addressing Alabama’s health disparities should be comprehensive, targeted, well-funded, and willing to stretch the boundaries of traditional medical care.**

In many states, people tend to look to their state public health department to implement programs and initiatives that address the state’s health disparities and any alarming health trends. Unfortunately, because of a severely limited budget and long-standing neglect by the state legislature, the Alabama Department of Public Health (ADPH) struggles to perform that function on a large scale. April Golson, the Telehealth Program Manager at ADPH, commented on the lack of state funding for the department: “The legislature doesn’t fund us because we are not a priority for them at this point.” In addition to a lack of funding, it seems the conservative state legislature expects ADPH to work within a fairly strict set of boundaries. Carrie Allison, the Director

of the Office of Performance Management at ADPH, defined the Department’s role in the state’s health care landscape: “Public health in general does not take on the role of competing with private sector. Our role is to fill the gap that private sector does not fill.” For countless reasons, many previously mentioned in this report, that “gap” in Alabama is simply too large, far too large for an underfunded, underprioritized state public health department to fill.

Based on the interviewees’ insights, it seems the programs that have enjoyed the most success in the Black Belt have been those that provide patients with comprehensive support. Sowing Seeds of Hope in Marion, AL, run by Executive Director Frances Ford, is one such program. The work of the organization spans many sectors and includes building new houses with grants from the USDA’s Rural Development Program, running a weekly Cardiovascular Risk Reduction Clinic, and hosting parenting class for local residents. Mrs. Ford described the



#### **Whatley Health Services at Eutaw**

Eutaw, AL (pop. 2,652)

mission of Sowing Seeds of Hope: “We’re one of those organizations that when people come in, whatever they have a need for we try to see if we can find an answer.” Medical Advocacy and Outreach, led by Mike Murphree and Laurie Dill, maintains a similar approach to care, serving Alabamians with life-threatening illness.

Many interviewees expressed their support for a community health worker model or something similar. Such a model, many pointed out, would be able to take advantage of the strong community relationships in the Black Belt. Dr. Dill underscored the benefits of implementing programs proven to work in poor, rural regions like the Black Belt, even if that means importing “new” ideas from outside the United States: “There are some ways that models from Cuba, Haiti, and Africa fit rural Alabama better than models from Boston, Birmingham, or Atlanta.” While many agree that a geographically comprehensive community health worker model holds promise in the Black Belt, there is much uncertainty about who would be best equipped to establish and maintain such a program. What Dr. Dill and others did make clear, though, is that, despite its excellent leadership, they did not think the Alabama Department of Public Health was the best-positioned to spearhead the initiative, due to its severely limited funding and vulnerability to political influence.

Several interviewees were adamant that the replacement of racist policies with neutral policies is not enough. Instead, they argued, it is time for programs and initiatives that directly target and empower Black Alabamians. Dr. Harris explained it this way: “Racism continues to be a problem. The easiest out for people today is just to say, ‘There’s not Jim Crow laws. We’re all equal. Everyone gets treated the same.’ That’s just not realistic. You can’t undo a hundred and fifty years of this by saying, ‘You’re on your own. There’s no racism.’” Mr. Zippert offered an alternative to these harmful neutral policies: “Shouldn’t there be some compensation? Instead of saying we’re a small rural hospital so we get more payment, maybe we should get an incentive because we are serving the person who has been historically underserved.” Programs like this quasi-reparations model proposed by Zippert—models with a commitment to redressing the trauma inflicted on the Black populations of the Black Belt for centuries—are aptly emblematic of the gravity and scope of the region’s challenges, as well as the solutions needed to address them.

## LOOKING AHEAD

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These insights from a wide range of Black Belt stakeholders perhaps generate more questions than answers. For a region as understudied as the Black Belt, that is not at all problematic. As Mr. Carnes put it, the region has “just about every challenge you could throw at it,” and addressing any and all of these challenges is going to require the formulation of many more questions. In the Black Belt, a “perfect” storm of extreme poverty, inadequate housing, high rates of uninsurance, hospital closures, systemic and institutional racism, and educational inequities has resulted in some of the nation’s poorest health outcomes. It is now the responsibility of state and local governments, academic researchers, and health advocates nationwide to acknowledge and address this tragedy, one that has been allowed to persist in our country for far too long.

Based on these interviews, the first step in alleviating health disparities in Alabama’s Black Belt should be expanding the state’s Medicaid program. Most directly, Medicaid expansion would extend access to health care to the 140,000 Alabamians who currently fall in the coverage gap.<sup>20</sup> As mentioned previously, expansion also has the potential to alleviate seemingly non-health-related challenges currently faced by the state, such as mass incarceration. The expansion of comprehensive support programs like Sowing Seeds of Hope should accompany Medicaid expansion to provide Black Belt residents with assistance navigating available resources. Finally, more thought should be given to the development and implementation of initiatives that serve to directly target and reverse the injustices long endured by Black communities in the Black Belt.

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<sup>20</sup>Garfield, Rachel, Kendal Orgera, and Anthony Damico. “The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,” Henry J. Kaiser Family Foundation Issue Brief (2019). <http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid>.



### Physicians Care Sweet Water

Gilbertown, AL (pop. 197)

While this report only includes analysis of limited qualitative data, it must be noted that more quantitative data is needed to generate the research products necessary for definitive and actionable policy recommendations. Collecting accurate and reliable data in isolated rural communities is always quite difficult, but it is precisely what is needed to better understand the complex interaction of socioeconomic and behavioral factors fueling the region's health inequities.

Perhaps the most important takeaway from these interviews was the need for a heightened national awareness. Residents of Alabama, and presumably those of other Black Belt states, are typically well aware of the struggles of the Black

Belt, while people in other regions of the country are not even aware of the existence of the term “Black Belt,” let alone the centuries-long legacy of slavery, segregation, and ongoing neglect that it connotes. In explaining her frustration with the lack of broader awareness, Dr. Peterson remarked,

“People can't change what they don't know.” A principle purpose

**“People can't change what they don't know.”**

of this report, and hopefully of any that will follow, is to inform the American public of the unacceptable state of affairs in the Black Belt, to open readers' eyes to the millions of citizens America has left behind, and to demand a better future for all Americans regardless of their zip code or the color of their skin.

## APPENDIX

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1. Can you tell me a little bit about yourself and the work you do?
2. Can you describe the health care ecosystem in Alabama's rural Black Belt counties? Where and when do people go for care? What are the most formidable barriers to accessing care?
3. How, if at all, has the Affordable Care Act changed rural health in Alabama?
4. Alabama has some of the most stringent Medicaid eligibility requirements and has not expanded Medicaid under the ACA. What impact do you think Medicaid expansion would have on the health of Alabama's rural Black counties? How do you think the implementation of a "Medicare for All" system would impact the health of low-income and minority rural populations?
5. Can you discuss how residents' physical environment (e.g. housing, segregation, dominant industries and occupations, etc.) plays a role in determining health outcomes?
6. The demographics of Alabama's rural population, especially its poor rural population, are much more diverse than those of poor rural populations in other regions of the country. Can you speak to the role of race and racism in propagating health disparities in the Black Belt?
7. In your experience, what are some unique strengths possessed by the residents and communities of the Black Belt?
8. What programs or initiatives are currently in place to address the region's health inequities?
9. Are there any rural health care models or programs that you have seen implemented elsewhere—in another state or country—that you think hold promise in Alabama's Black Belt?
10. How are you or your organization dealing with the complexity and multifactorial interaction fueling these disparities? What issues have you and your organization been primarily focusing on (e.g. health care provider and/or facility availability, poverty, education, segregation, Medicaid and insurance coverage, social capital development, etc.) in addressing the disparities?
11. Are you optimistic that health disparities in this region will be alleviated in the future?
12. Have you or your organization conducted any research or generated any reports on the topic of rural minority health or health in the Black Belt specifically?
13. What should a public health researcher like myself know about the Black Belt—its residents and its communities—that is not readily apparent from academic articles and web searches?



DOCTOR

DOCTOR

**Pine Apple Health Center**

Pine Apple, AL (pop. 119)

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