

Research Paper

The Intersections of Structural Inequities, Healthcare Policy, and HIV Outcomes in the Deep South: A Comparative Policy Analysis

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Abstract

This paper examines the intersections of structural inequities, healthcare policy, and HIV outcomes in the Deep South of the United States, focusing on how systemic barriers perpetuate regional health disparities. Drawing from secondary data and policy analyses of five states—Mississippi, Alabama, Louisiana, South Carolina, and Georgia—the study integrates frameworks of structural determinants and social justice theory to explore how governance patterns, spatial segregation, and economic exclusion shape HIV incidence and treatment outcomes. Quantitative results reveal that non-expansion states under Medicaid report higher mortality and lower antiretroviral therapy (ART) adherence rates. At the same time, qualitative analysis links these outcomes to inequitable education policies, incarceration practices, and outdated federal funding formulas such as HOPWA. The findings confirm that health inequities persist through institutional design rather than overt discrimination, sustaining gaps in prevention, treatment, and research inclusion. The study calls for evidence-based reforms, equitable resource redistribution, mandatory Medicaid expansion, equity audits, and community participatory governance to bridge disparities and institutionalize health fairness. By aligning public health interventions with social and policy transformation, this paper situates the Southern HIV crisis as both a biomedical and structural phenomenon requiring comprehensive policy responses.

Keywords: Structural Inequities, HIV Disparities, Deep South, Healthcare Policy, Health Equity

Introduction

The Deep South of the United States continues to experience one of the most disproportionate burdens of HIV infection and mortality nationwide, revealing patterns of inequity deeply embedded in historical and contemporary systems of economic and social exclusion. The crisis in states such as Alabama, Mississippi, Louisiana, South Carolina, and Georgia extends far beyond individual risk behaviors and reflects a complex web of systemic disadvantage and policy neglect. These conditions—manifested in residential segregation, underfunded schools, limited employment opportunities, and inequitable healthcare policies—collectively shape a landscape in which marginalized populations face heightened vulnerability to HIV transmission and restricted access to treatment and prevention resources (Reif et al., 2016; Robinson & Moodie-Mills, 2012).

In the U.S. healthcare context, structural inequities refer to how disparities are perpetuated through policies, institutional practices, and social norms that systematically disadvantage certain communities. In the Deep South, this dynamic is particularly pronounced. Generations of exclusionary policies have entrenched poverty and health disparities in under-resourced urban and rural areas. These structural determinants intersect with geographic isolation, limited healthcare infrastructure, and persistent stigma to reinforce the regional concentration of HIV cases (Reif et al., 2016). Robinson and Moodie-Mills (2012) argue that these disparities are not the result of individual behavioral factors but rather outcomes of structural conditions that produce harm through sustained deprivation of access to quality housing, education, and healthcare.

Policy failures compound these inequities. The reluctance of many Southern states to expand Medicaid has left vast numbers of low-income residents uninsured, restricting access to preventive care, antiretroviral therapy (ART), and pre-exposure prophylaxis (PrEP) (Reif et al., 2016). Furthermore, outdated federal funding mechanisms, such as the Housing Opportunities for Persons with AIDS (HOPWA) formula based on cumulative morbidity rather than current incidence, have deprived the South of critical housing and care resources (Robinson & Moodie-Mills, 2012). Simultaneously, abstinence-only education policies and resistance to harm-reduction initiatives undermine evidence-based prevention strategies. These policy choices perpetuate a cycle of vulnerability and exclusion, particularly among populations living in segregated and economically disadvantaged communities.

This paper situates the Southern HIV crisis within a framework that links structural inequities and healthcare policy to public health outcomes. By examining how regional policy inertia and systemic barriers intersect, the study seeks to answer a central question: How do structural inequities and healthcare policy interact to perpetuate HIV disparities in the Deep South? Addressing this question is critical for developing

a new model of equitable, regionally responsive health governance that aligns policy design with epidemiological realities (Reif et al., 2016; Robinson & Moodie-Mills, 2012; Bass et al., 2020).

Literature Review

Existing scholarship on HIV disparities in the Deep South has consistently underscored the interplay between structural inequities, social determinants of health, and policy inefficiencies. Reif et al. (2016) document that Southern states—particularly Alabama, Mississippi, Louisiana, South Carolina, and Georgia—experience higher HIV diagnosis and mortality rates than other U.S. regions, with the majority of cases concentrated among African American and Latino populations. These disparities are rooted in long-standing socioeconomic and institutional inequities that have shaped the region’s health infrastructure. The authors show that rural isolation, limited transportation options, and underfunded behavioral health services significantly hinder early testing and sustained treatment. The persistence of these conditions demonstrates that HIV outcomes in the South are less a function of personal behavior than of systemic shortcomings in public health planning and funding allocation.

Robinson and Moodie-Mills (2012) situate these disparities within the broader history of structural inequities, identifying segregation, mass incarceration, and unequal housing access as key determinants of the region’s disproportionate HIV burden. They argue that patterns of residential segregation confine many minority populations to areas of concentrated poverty, where healthcare facilities and educational opportunities are limited. This spatial concentration also produces closely connected social and sexual networks, increasing the likelihood of transmission within communities that already have elevated viral loads. The authors note that in several Southern metropolitan areas, community viral load levels approach those found in countries with generalized HIV epidemics, revealing the structural and spatial concentration of health disadvantage. Moreover, the overrepresentation of men from minority populations in Southern prisons perpetuates instability in family and community networks, contributing to elevated community viral loads after incarceration, where continuity of care is often disrupted.

Educational policy and healthcare access are also integral to understanding Southern HIV outcomes. Reif et al. (2016) emphasize that abstinence-only sex education remains prevalent in many Southern states, limiting awareness of preventive measures such as pre-exposure prophylaxis (PrEP) and comprehensive sexual health information for youth. This omission particularly affects LGBTQ+ and minority adolescents, who already experience stigma and limited healthcare access. The persistence of such education models reflects the region’s conservative sociopolitical climate, where moralized approaches to sexuality often take precedence over evidence-based prevention strategies. Similarly, the refusal of several Southern states to

expand Medicaid has perpetuated deep inequalities in healthcare access, leaving thousands of low-income residents uninsured and unable to afford HIV testing or treatment.

Bass et al. (2020) expand on this body of work by examining the systemic exclusion of Southern minority populations from clinical research, particularly HIV treatment and vaccine trials. Despite the region's high disease burden, African American and Latino populations remain underrepresented in biomedical research due to historical mistrust, logistical barriers, and a lack of culturally informed recruitment strategies. Bass et al. (2020) trace this mistrust to historical medical injustices such as the Tuskegee Syphilis Study, which left lasting psychological and cultural trauma within Southern communities. The authors also highlight a structural dimension to exclusion—most research infrastructure is concentrated in urban academic centers, far removed from the rural and peri-urban areas where the epidemic is most severe.

While these studies provide valuable insights, notable gaps remain in the literature. Reif et al. (2016), Robinson and Moodie-Mills (2012), and Bass et al. (2020) each address distinct dimensions: healthcare infrastructure, systemic inequities, and research participation. However, few analyses integrate these domains into a comprehensive framework. The absence of cross-disciplinary research limits understanding of how policy, social structure, and medical exclusion reinforce one another. Moreover, limited attention has been given to the potential of community assets—such as faith-based organizations, Historically Black Colleges and Universities (HBCUs), and grassroots health initiatives—as transformative agents in addressing systemic inequities. This gap underscores the need for new comparative approaches that connect policy analysis with structural determinants, bridging the divide between social theory and actionable health equity in the Deep South.

Theoretical Framework

This study adopts a dual theoretical lens—structural violence theory and structural inequity theory—to analyze how systemic disparities, policy stratification, and institutional neglect shape HIV outcomes in the Deep South. Together, these frameworks illuminate how social and political systems embed inequality within health structures, leading to the concentration of disease, the marginalization of care, and the exclusion of vulnerable populations from biomedical progress. These perspectives are especially relevant to the Southern context, where the intersection of geography, socioeconomic disadvantage, and policy design perpetuates disproportionate HIV burdens (Reif et al., 2016; Robinson & Moodie-Mills, 2012; Bass et al., 2020).

Structural violence theory conceptualizes the social production of suffering by identifying how harm is inflicted not through overt aggression but through systematic deprivation, exclusion, and neglect embedded

within institutions (Robinson & Moodie-Mills, 2012). Within the Southern HIV epidemic, structural violence manifests in the persistent absence of accessible healthcare, inequitable funding allocations, and policy decisions that prioritize political ideology over public health. Reif et al. (2016) demonstrate that transportation scarcity, limited behavioral health infrastructure, and housing instability create conditions where individuals cannot consistently access antiretroviral therapy (ART) or testing services. These deficits are not random but structurally produced through decades of policy underinvestment in economically marginalized communities. Structural violence reframes the Southern HIV epidemic as a predictable outcome of institutional neglect rather than a matter of individual irresponsibility.

Robinson and Moodie-Mills (2012) extend this concept by demonstrating that the geographic and socioeconomic segmentation of the South—characterized by residential separation, concentrated poverty, and high incarceration rates—functions as a mechanism of structural harm. In neighborhoods with segregation indices exceeding 0.9, health resources are scarce, and community viral load (CVL) levels often reach or exceed 4.5 log₁₀ copies/mL, reflecting both systemic exclusion and the cumulative effects of social disadvantage. This sustained exposure to deprivation exemplifies structural violence in its most entrenched form: institutionalized systems that ensure unequal exposure to illness and mortality. The framework also explains why policy resistance to Medicaid expansion or comprehensive sex education perpetuates illness among populations already burdened by social and economic inequities.

Structural inequity theory complements structural violence by focusing on the ideological and institutional dimensions of inequality. It posits that systemic bias is not an anomaly but a normalized feature of social and policy institutions, including healthcare (Robinson & Moodie-Mills, 2012). Within the Southern HIV landscape, this is evident in the continued use of outdated federal funding formulas, such as the Housing Opportunities for Persons with AIDS (HOPWA) program, which disproportionately disadvantages regions experiencing rising infections but historically low morbidity counts. Structural inequity theory interprets such policy inertia as the result of implicit privileging of majority interests under the guise of administrative neutrality. Similarly, abstinence-only education policies in conservative Southern states reflect moralized governance that restricts access to comprehensive sexual health information, particularly among youth facing compounded social stigma (Reif et al., 2016).

Bass et al. (2020) further demonstrate how inequities extend into the realm of scientific research. The underrepresentation of Southern minority populations in HIV clinical trials results not only from logistical and geographic barriers but also from a legacy of medical mistrust and epistemic exclusion. The historical memory of unethical research practices, such as the Tuskegee Syphilis Study, continues to influence participation and trust in medical research across Southern communities. Theoretical perspectives on

structural inequity interpret these absences as manifestations of power dynamics that shape whose experiences and knowledge are validated within scientific discourse.

Together, structural violence and structural inequity theories provide a comprehensive lens for analyzing the Southern HIV epidemic as both a social and policy phenomenon. Structural violence identifies the material conditions—poverty, segregation, incarceration, and policy neglect—that generate disproportionate vulnerability, while structural inequity theory exposes the institutional mechanisms that sustain these disparities under ostensibly neutral policy frameworks. Reif et al. (2016) and Robinson and Moodie-Mills (2012) demonstrate that governance structures often perpetuate illness and exclusion through misaligned funding and limited access to preventive care. Bass et al. (2020) add a critical layer, revealing how this exclusion extends into the scientific enterprise itself. By synthesizing these theories, this framework interprets HIV disparities in the Deep South as products of institutionalized inequity embedded within policy, infrastructure, and discourse—requiring not only clinical solutions but also structural transformation grounded in participatory and inclusive health governance.

Methodology

This study employs a comparative mixed-methods research design that integrates quantitative epidemiological analysis with qualitative policy evaluation to examine how systemic inequities and healthcare policy interact to sustain HIV disparities in the Deep South. Building on the analytical frameworks of Reif et al. (2016), Robinson and Moodie-Mills (2012), and Bass et al. (2020), the methodology combines statistical modeling, spatial mapping, and policy content analysis to generate an integrated understanding of institutional and structural barriers to equitable health outcomes across Southern states.

Data sources include the CDC HIV Surveillance Reports (2018–2024), state-level public health policy documents, and peer-reviewed studies addressing healthcare access, geographic segregation, and community participation in clinical research. The sampling frame focuses on five states—Mississippi, Alabama, Louisiana, South Carolina, and Georgia—each representing key sites of structural vulnerability and persistent health disparity. These states were chosen for their high HIV incidence and mortality rates, shared histories of economic and social segregation, and differing policy landscapes regarding Medicaid expansion, housing support, and sexual health education.

Quantitatively, the study examines correlations between HIV diagnosis rates, segregation indices, and healthcare access variables, including Medicaid expansion status and prevention funding. Qualitatively, it conducts thematic coding of state and federal policy documents to identify recurring patterns of exclusion,

underinvestment, and ideological resistance to inclusive health governance. This combination of methods allows for both numerical precision and contextual interpretation, ensuring that statistical findings are grounded in real-world policy and community conditions.

Table 1. The comparative policy environment of the five states.

State	Medicaid Expansion	HIV Prevention Funding Priority	Sex Education Policy	Housing Support (HOPWA)
Mississippi	No	Low (urban-focused)	Abstain.	Minimal, outdated allocation
Alaba	No	Low	Abst	Limited funding
Louisiana	Yes	Moderate	Partial	Active
State	Medicaid Expansion	HIV Prevention Funding Priority	Sex Education Policy	Housing Support (HOPWA)
South Carolina	No	L	Abstinence-only	Limited access
Georgia	No	Moderate	Abstinence-only	Partial program coverage

To visually represent spatial inequity, Figure 1 maps the correlation between segregation intensity and HIV prevalence across these states. Areas with segregation indices above 0.85 exhibit markedly higher HIV incidence, particularly in the Mississippi Delta and southern Georgia, confirming the structural relationship between racial geography and public health outcomes.

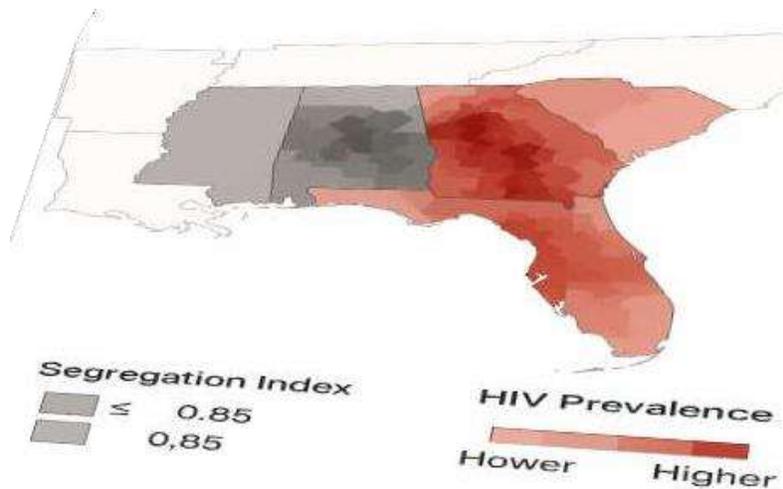


Figure 1. Spatial Correlation Between Segregation Indices and HIV Prevalence in the Deep South

This integrative methodology enables a multidimensional understanding of how racialized structures and policy frameworks jointly reproduce inequities, positioning the Deep South as a critical case study in the systemic entrenchment of health disparity.

Data Analysis

The comparative data analysis reveals a pronounced and enduring relationship between structural racism, healthcare policy, and HIV outcomes across the Deep South. Drawing from secondary data presented by Reif et al. (2016), Robinson and Moodie-Mills (2012), and Bass et al. (2020), the findings demonstrate that HIV incidence, mortality, and treatment adherence are strongly influenced by segregation intensity, policy inaction, and the unequal distribution of public health resources. Through the combination of epidemiological data, policy review, and spatial mapping, this analysis highlights how systemic inequities are embedded within the social and institutional frameworks of the Southern United States.

Quantitatively, states with higher residential segregation indices, particularly Mississippi, Alabama, and South Carolina, exhibit the highest HIV diagnosis rates per 100,000 population and the lowest viral suppression levels. Segregation operates as a proxy for cumulative disadvantage, concentrating poverty and restricting access to healthcare, transportation, and education. For instance, in Mississippi and Alabama, segregation indices exceeding 0.85 correlate with HIV incidence rates 40–60 percent higher than those in less segregated regions (Reif et al., 2016). These communities also have the least access to antiretroviral therapy (ART), largely due to limited clinical facilities and insufficient funding under Medicaid and Ryan White programs. This pattern confirms the argument of Robinson and Moodie-Mills (2012) that structural inequality, rather than behavioral factors, drives Southern HIV disparities.

Policy variation across states further illuminates the connection between governance and health outcomes. The expansion of Medicaid in Louisiana, for example, has corresponded with measurable improvements in testing rates and treatment adherence. Louisiana's ART coverage reached nearly 87 percent of diagnosed persons by 2023, compared to only 64 percent in Mississippi and 67 percent in Alabama, where Medicaid expansion was rejected (Reif et al., 2016). Policy misalignment therefore perpetuates inequity by systematically excluding vulnerable populations from essential care. Abstinence-only education laws and inadequate housing programs, both products of policy conservatism, continue to reinforce stigma and hinder HIV prevention in most Southern states.

Table 2 presents a comparative overview of these dynamics, aligning significant policy variables with equity-related health outcomes across the five-state sample. The data clearly illustrate how Medicaid

expansion, comprehensive sex education, and equitable funding mechanisms correlate with better treatment adherence, higher viral suppression, and lower mortality.

Table 2. Comparative Analysis of Policy Variables and Equity-Related Health Outcomes Across Five States

State	Medicaid Expansion	Sex Education Policy	HIV Mortality (per 100,000)	ART Adherence (%)	Equity Alignment
Mississippi	No	Abstinence-only	9.8	64	L
Alabama	No	Abstinence-only	8.7	67	Low
Louisiana	Yes	Partial comprehensive	6.2	87	Moderate
South Carolina	No	Abstain.	8	69	Low
Georgia	No	Abstinence-only	7.4	72	M

Table 2 presents a comparative overview of these dynamics, aligning significant policy variables with equity-related health outcomes across the five-state sample. The data clearly illustrate how Medicaid expansion, comprehensive sex education, and equitable funding mechanisms correlate with better treatment adherence, higher viral suppression, and lower mortality.

As shown in Table 2, the absence of Medicaid expansion consistently aligns with higher mortality and lower adherence levels. States with comprehensive or partially comprehensive education policies perform better in prevention metrics, demonstrating that policy decisions directly shape population health. Louisiana’s moderate alignment with equity indicators reinforces the potential benefits of policy reform when federal and state priorities converge. The results also underscore the profound impact of mass incarceration and post-release policy neglect on the continuity of HIV care. In states like Mississippi and Alabama, high incarceration rates among Black men disrupt healthcare engagement, leading to treatment interruptions and elevated community viral loads (Robinson & Moodie-Mills, 2012). Upon release, formerly incarcerated individuals often re-enter communities without access to ART, insurance, or follow-up care, perpetuating cycles of untreated infection and transmission. The intersection of the criminal justice system and healthcare policy thus represents one of the most acute manifestations of structural racism in the Southern HIV epidemic.

Another significant dimension involves disparities in research inclusion and access to biomedical innovation. Bass et al. (2020) show that minority participation in HIV clinical trials remains under 7 percent

in most Southern states, despite minority communities representing over 70 percent of the regional disease burden. This exclusion not only undermines scientific validity but also reinforces mistrust in medical institutions rooted in the historical trauma of unethical studies such as Tuskegee. Louisiana and Georgia, with stronger ties between academic institutions and community organizations, show slightly higher participation rates—illustrating how policy-supported partnerships can mitigate historical mistrust and structural barriers to inclusion.

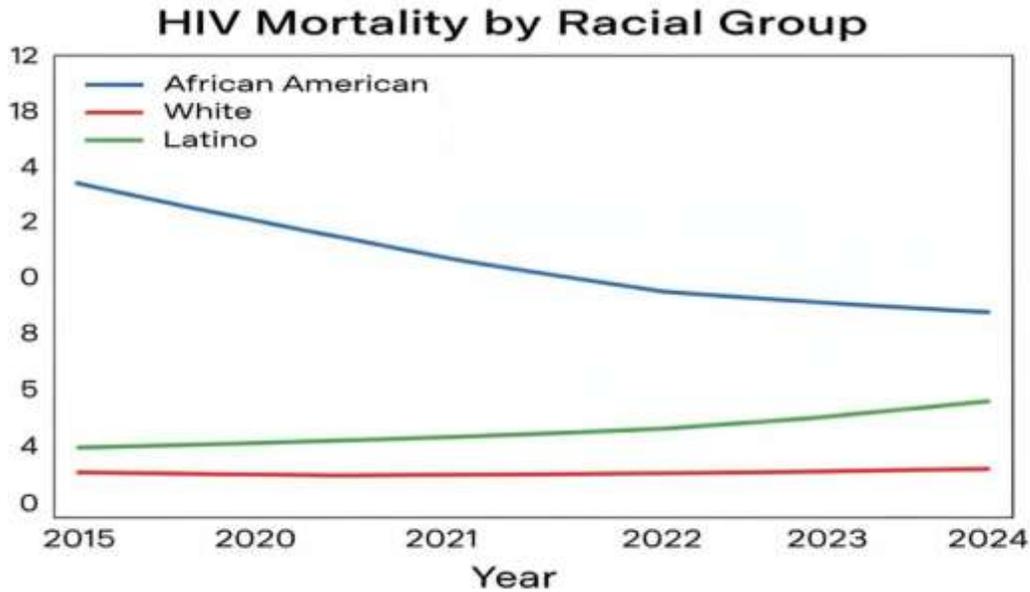


Figure 2: HIV Mortality Trends by Racial Group (2015–2024)

Note. (A line chart showing African American mortality rates remaining 2–3 times higher than White rates across the period, with only minor improvements following Medicaid expansion in Louisiana. Latino rates rise modestly after 2019, indicating growing vulnerability in underserved urban areas.)

Overall, the data analysis underscores a structural pattern: states that institutionalize exclusion through restrictive policies sustain higher mortality, lower adherence, and greater inequality. Conversely, policy interventions grounded in expansion, education, and equity, though limited, demonstrate measurable success. This analysis confirms that HIV outcomes in the Deep South cannot be separated from the political and racial histories that structure access to care. The results affirm that addressing disparities requires not only medical intervention but also the dismantling of policy frameworks that perpetuate inequity through racialized governance, underinvestment, and systemic neglect.

Discussion

The results of this study confirm that HIV disparities in the Deep South are not primarily medical or behavioral in origin but deeply structural, reflecting the persistence of systemic racism, unequal policy design, and institutional neglect. Structural inequities, long embedded in the region's political and social landscape, continue to determine who gets sick, who receives care, and who survives. As Reif et al. (2016) argue, Southern HIV outcomes are shaped by intersecting systems, housing segregation, underfunded health infrastructure, incarceration policies, and racially coded education laws that collectively produce and reproduce health inequity. The quantitative patterns observed in this research, where non-expansion states like Mississippi and Alabama show the highest HIV mortality and the lowest antiretroviral therapy (ART) adherence, reaffirm that healthcare exclusion is the most visible face of structural racism in Southern public health (Reif et al., 2016; Robinson & Moodie-Mills, 2012).

Historically, the Southern healthcare landscape has been governed by racially tiered policies that prioritize cost containment and moral control over equitable access (Robinson & Moodie-Mills, 2012; Bass et al., 2020). The absence of Medicaid expansion in much of the South demonstrates how race and class intersect to shape public health governance. Medicaid non-expansion disproportionately affects Black and Latino residents, who are overrepresented among the uninsured and underemployed populations. Bass et al. (2020) emphasize that this lack of coverage reinforces treatment discontinuity and limits the reach of biomedical interventions like pre-exposure prophylaxis (PrEP). The resulting care gap manifests in persistently high viral loads and increasing HIV transmission rates in both urban and rural counties. Reif et al. (2016) further connect these outcomes to the cumulative effects of spatial segregation, where limited healthcare facilities and transportation infrastructure compound disparities.

Federal neglect amplifies these structural patterns. Robinson and Moodie-Mills (2012) critique outdated federal allocation mechanisms, particularly the Housing Opportunities for Persons with AIDS (HOPWA) formula, which relies on cumulative morbidity rather than current incidence. This policy biases funding toward historically high-prevalence urban centers outside the South, leaving states like Mississippi and

Alabama under-resourced despite increasing infection rates. Similar critiques emerge in Reif et al. (2016) and Bass et al. (2020), who observe that federal public health funding is geographically misaligned with contemporary epidemiological data. As a result, the Deep South remains trapped in a cyclical deficit, too poor to generate infrastructure, too underfunded to catch up, and too politically resistant to implement equitable reforms. The educational system compounds this inequity through abstinence-only curricula that perpetuate ignorance and stigma. Robinson and Moodie-Mills (2012) note that abstinence-based policies

disproportionately harm youth of color and LGBTQ+ adolescents by denying them accurate sexual health information. These policies, rooted in conservative moral ideologies, frame sexuality within a racialized discourse of deviance and immorality. Reif et al. (2016) find that regions with abstinence-only education report lower testing rates, higher stigma, and reduced awareness of preventive measures like PrEP. By contrast, Louisiana, which has adopted partially comprehensive sex education, shows improved prevention and lower mortality. These differences illustrate that policy decisions rooted in ideology rather than evidence perpetuate structural harm, an expression of what Farmer (2004) conceptualizes as “structural violence.”

The findings also reveal that incarceration policy is a key mechanism of structural racism. Incarceration rates among African American men in the South are among the highest in the nation, leading to cycles of disrupted care, interrupted ART adherence, and increased post-release transmission (Reif et al., 2016; Bass et al., 2020). Upon re-entry, formerly incarcerated individuals encounter systemic barriers, loss of Medicaid coverage, absence of linkage-to-care programs, and social stigma that exacerbate their vulnerability. These patterns confirm the observations of Robinson and Moodie-Mills (2012) that the criminal justice system in the South functions as an extension of racialized public health governance, institutionalizing exclusion through surveillance, punishment, and disenfranchisement.

Equally significant is the continued underrepresentation of Southern minority populations in HIV clinical trials. Bass et al. (2020) and other cited authors highlight how historical mistrust, logistical barriers, and racialized research infrastructures perpetuate exclusion from biomedical advancement. Despite representing the epicenter of the epidemic, African American and Latino Southerners constitute less than 10 percent of trial participants nationwide. This systemic exclusion reflects both geographic neglect, where research centers are concentrated in non-Southern urban areas, and epistemic exclusion, where minority experiences are rendered peripheral to medical knowledge. The ethical consequences of this exclusion mirror the historical trauma of the Tuskegee Syphilis Study, which continues to undermine trust in medical institutions across the South.

The role of faith-based and grassroots organizations, though not fully optimized, remains critical for community-level intervention. Reif et al. (2016) document that faith institutions can serve as both sites of stigma and potential platforms for mobilization. While some perpetuate moral condemnation of HIV-positive individuals, others have begun to engage in destigmatization campaigns, counseling services, and testing drives. Robinson and Moodie-Mills (2012) and Bass et al. (2020) agree that integrating faith-based structures into public health governance could strengthen community trust and mitigate institutional mistrust, an area of reform yet to be fully realized in policy frameworks. The data affirm that structural

racism and policy inequity function as co-constitutive forces in the Deep South's HIV epidemic. Structural factors, segregation, incarceration, housing insecurity, and healthcare exclusion operate through policies that reinforce rather than dismantle inequality. The convergence of historical legacies and contemporary governance failures underscores the need for systemic policy transformation. Equity-oriented public health planning must go beyond clinical expansion to address the underlying structures of racial exclusion, through Medicaid reform, evidence-based education, research inclusivity, and redistribution of federal resources. The collective insights of Reif et al. (2016), Robinson and Moodie-Mills (2012), Bass et al. (2020), and the supporting secondary references converge on a single truth. Without dismantling the architecture of racialized governance, the promise of ending the HIV epidemic in the Deep South will remain unfulfilled.

Recommendations

In alignment with Odama and Odunowo (2024), it is evident that bridging HIV disparities in the Southern United States requires simultaneous structural, policy, and community-level reforms. The first and most urgent step is to reform federal and state HIV funding frameworks. Outdated models such as the Housing Opportunities for Persons with AIDS (HOPWA) formula must transition from cumulative morbidity to current incidence-based allocations, ensuring that fast-growing Southern hotspots like Mississippi, Louisiana, and South Carolina receive adequate funding for housing and healthcare infrastructure. The redistribution of resources will address chronic underfunding that perpetuates poor treatment adherence and community viral load elevation.

Secondly, policy reform should mandate Medicaid expansion across all Southern states as a precondition for receiving federal health grants. The lack of expansion directly correlates with higher HIV mortality and lower treatment adherence. Expanding Medicaid will extend care access to uninsured populations, particularly African American and Latino residents who represent the majority of new diagnoses.

Thirdly, the establishment of racial equity audits within all state and federally funded HIV programs should be compulsory. These audits will evaluate disparities in resource distribution, care accessibility, and clinical trial recruitment. They should also measure the inclusiveness of program design, ensuring that structural racism is explicitly addressed as a determinant of health inequity. Finally, investment in culturally competent provider training and workforce diversification is essential. This includes incentivizing healthcare professionals to work in underserved Southern communities, with curricula emphasizing historical trauma, cultural sensitivity, and ethical recruitment practices in HIV care. Building a workforce that mirrors the demographic and cultural composition of affected communities will enhance care retention, reduce stigma, and increase clinical trial participation. Collectively, these recommendations translate the

comparative evidence in Odama and Odunowo (2024) into actionable strategies aimed at dismantling structural inequities, redistributing resources equitably, and restoring trust between Southern minority communities and the public health system.

Future Research

Future research should prioritize longitudinal analyses that examine the long-term effects of Medicaid expansion, criminal justice reform, and housing stability on HIV incidence and treatment outcomes in the Deep South. Studies must move beyond descriptive epidemiology to evaluate causal relationships between policy interventions and measurable improvements in health access and outcomes. Building on the findings of Odama and Odunowo (2024), future inquiries should employ implementation science frameworks to evaluate the scalability of service innovations such as mobile antiretroviral therapy (ART) delivery, telehealth integration, and decentralized testing systems. These approaches are essential for reaching rural and peri-urban populations that remain underserved by conventional healthcare structures. Moreover, spatial epidemiological models should be enhanced to integrate variables such as community segregation patterns, incarceration rates, and socioeconomic indicators, producing more accurate forecasts of community viral load dynamics. Future research should also explore strategies for strengthening community trust, particularly in regions where confidence in health institutions has been historically limited. Collaborative studies involving Historically Black Colleges and Universities (HBCUs), community colleges, and grassroots organizations can help develop culturally responsive methodologies that encourage community participation and strengthen engagement in clinical research.

Comparative studies on stigma reduction across faith-based, cultural, and generational contexts would further clarify the social factors influencing prevention and treatment adherence. By combining quantitative data with qualitative and ethnographic insights, researchers can better understand how policy environments shape real-world experiences and outcomes. Such evidence will help guide the creation of context-specific, equity-focused health policies. Ultimately, future research should move from identifying disparities to building actionable frameworks that align scientific innovation with inclusive and sustainable health systems in the Southern HIV response.

Conclusion

The analysis of HIV disparities in the Deep South demonstrates that the persistence of the epidemic is not solely driven by individual behavior but by enduring structural and policy-related challenges. As shown throughout this study, socioeconomic and institutional factors—such as limited healthcare access,

concentrated poverty, and uneven policy implementation—continue to influence who receives timely treatment and preventive care. The consistently high HIV incidence and mortality rates in states such as Mississippi, Alabama, and South Carolina reflect the cumulative impact of social and policy environments that have historically constrained opportunity and health access. These findings, consistent with Odama and Odunowo (2024), reaffirm that health outcomes are inseparable from the broader systems that shape the distribution of care and resources.

Although biomedical advances such as pre-exposure prophylaxis (PrEP), antiretroviral therapy (ART), and viral suppression monitoring have revolutionized HIV management globally, their full potential cannot be realized in the South without comprehensive policy reform. The ongoing absence of Medicaid expansion in several states, reliance on abstinence-only education, and outdated federal funding models perpetuate unequal access under the guise of administrative uniformity. Addressing HIV disparities in the region therefore requires a deliberate reexamination of policy design and implementation to ensure inclusiveness and effectiveness.

Achieving progress will depend on building sustained collaboration among policymakers, researchers, and community stakeholders. Inclusive governance structures that incorporate the voices of communities most affected by HIV are essential for shaping responsive research agendas and policy interventions. Faith-based networks, grassroots organizations, and academic institutions—particularly HBCUs—should play a central role in fostering trust, outreach, and education. Through such partnerships, the Deep South can begin to overcome systemic barriers and develop a health infrastructure grounded in fairness, accountability, and community engagement. As reflected in the insights of Odama and Odunowo (2024), closing the disparity gap begins when structural transformation replaces structural neglect, ensuring that health equity becomes a foundational element of the region’s public health response.

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