

Epistemic prejudice and geographies of innovation

Health disparities and unrecognized interventions in Mississippi

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Abstract

This article seeks to understand how and why certain locations are excluded from or seen as foreclosed as places of innovation and knowledge production in health research and practice. Rooted in several years of collaborative ethnographic research in Mississippi, we develop this conceptual framework to understand the persistence of – and often ineffective response to – racialized and classed health disparities. We define our concept of epistemic prejudice as a structural inability or resistance to seeing certain places, bodies, and locations as capable of knowledge production and innovation. The history of the community health center movement, paired with the portrayal of Mississippi in contemporary media representations, helps us develop our concept. We use an interface ethnography method as Mississippi scholars to demonstrate the importance of this model of research in understanding persistent inequality in places of ‘lack’, noting that the challenges of addressing health problems in Mississippi stem in part from epistemic prejudice of scholars, health care practitioners, and policy-makers. Epistemic prejudice has broader implications for how global health initiatives are implemented, how postcolonial frameworks still shape knowledge production, and how knowledge is generated and taken as authoritative.

Keywords

health disparities, knowledge production, geographies of knowledge, inequality, Mississippi, global South

Introduction

The American Deep South has often been a region of ridicule, embarrassment, and romanticism in US popular culture. Portrayals of the area as static and backward, yet homey and traditional abound in films such as *Deliverance* and *Sweet Home Alabama*. This narrative is, in many ways, self-perpetuating. And it was writ large in the 2017 Alabama Senate race between Roy Moore and Doug Jones. Jones, a Democrat, won in an upset over Moore, who had been accused of child molestation and sexual harassment. Moore, a former Supreme Court judge in the state, had been removed from the bench for various reasons, including making discriminatory statements and violating the separation of church and state. Part of the Jones campaign strategy was to emphasize that Alabama is not ‘backwoods’ anymore, in the way that Moore was seen to embody, particularly after he rode a horse to his polling place on election day. For many in the South and the United States more generally, Jones’s victory seemed to signal a glimmer of change in the region. Yet the Senate race occurred as international media outlets simultaneously emphasized the ‘re-emergence’ of hookworm in Alabama and the United Nation’s (UN) commission to study extreme poverty and inequality in the US, including in Alabama (Pilkington 2017; Ballesteros 2017). One UN official was widely quoted as saying that the poverty in Alabama was ‘the worst [he’d] ever seen’ in the developed world (Ballesteros 2017).

Like Alabama, Mississippi is often thought of as incomprehensible and inscrutable. During President Trump’s first cabinet meeting, Secretary of Agriculture Sonny Perdue was caught on audiotape saying, ‘While we’re bragging about international travel, I just got back from Mississippi!’ to laughter from the other cabinet members (Anderson 2017). Though some in Mississippi were deeply offended by this characterization, to us it seemed predictable. After all, in many journalistic accounts of Mississippi’s multiple health care crises, the state is often compared to African nations (Hasselle 2015; Ganguli 2013). Doing so casts the state as fundamentally ‘other’ to the rest of the United States, as foreign and not part of the national body. This has implications for how seriously Mississippi is taken as a case study, as a place where knowledge and innovation can be generated, generalized, and applied in other regions. In sum, the state (and the Deep South more generally) becomes easily dismissed, a joke, an odd and fundamentally particular place.

This fits another observation we have made: why is it that Mississippi is discussed at scholarly meetings in anachronistic language (such as ‘backward’)? Why, when we meet colleagues from other institutions, are we met with surprised looks when our geographical location is noted, or even, in more than one case, a response of ‘I’m sorry’? And this from careful scholars who would never describe, say, Guatemala as ‘backward’. Evidence that Mississippi is conceived as a sad joke is peppered throughout our professional interactions. It appears, almost recursively, in written depictions that portray the state as desperately poor,

sick, and tradition-bound. The overwhelming impression is of a place that is hopeless, that the world can and should give up on Mississippi's problems because they are in large part of the state's own making, due to entrenched racism, colonial legacies, and a resistance to change. And rather unfortunately, this dismissal of people and place occurs even among otherwise engaged scholars who work to ameliorate social, racial, and health inequalities.

Of course, Mississippi's population is poor and sick, with persistent health inequalities that do seem at times intractable. But this alone does not seem to justify the kind of cognitive dissonance we have observed. In this article, we argue that this dissonance is attributable, in part, to what we term 'epistemic prejudice': an orientation toward globally relevant knowledge production and influence that denies or underplays local complexity, practice, and insight. The consequences of this are profound. We find that epistemic prejudice enables certain assumptions to become taken-for-granted truisms about the world; it facilitates the construction of 'facts' on shaky, uncontested, or invalid foundations. Simultaneously, it serves to silence local innovation and creativity, making a kind of paradox of the local,¹ a place that is both so unique and so failed based on cosmopolitan standards that it barely deserves to be taken seriously and therefore has no generalizable insights to provide to other locations. This concept is applicable to contexts beyond Mississippi; though, as we argue, Mississippi is particularly good to think with as we explore epistemic prejudice.

This article is based on fieldwork examining the portrayal of health care in Mississippi. We used an inductive ethnographic case study methodology and worked collaboratively (discussed in more detail below). We situate ourselves within the growing field of critical global health, which makes an argument for the power of ethnography in understanding health disparities. Contextualizing our work within this field also serves to place Mississippi in a global framework in order to critique the portrayals of Mississippi as other that we have found in investigative journalism and research articles. In particular, we are inspired by the work of João Biehl and Adriana Petryna (2013, 12) who, in the introduction to their edited volume *When People Come First*, argue: 'We advocate "thinking in cases" (Geertz 2007:214). Much global health scholarship is invested in developing models. ... The form of the case

1 This is related to, but distinct from, what has been termed 'the local trap', which claims that 'political ecologists assume that organization, policies, and action at the local scale are inherently more likely to have desired social and ecological effects than activities organized at other scales' (Brown and Purcell 2005, 607). In many ways we are writing against this, and in fact suggesting that epistemic prejudice forecloses the idea that knowledge generated in places like Mississippi may be generalizable. Such knowledge is thus always seen as 'local' and in need of outside experts. Even local knowledge is not valuable in the context of being almost irredeemably other and particular.

brings granular ethnographic evidence to the forefront of analysis and enables analogical thinking'. 'Thinking in cases' reveals the disjuncture between the portrayal of Mississippi as a lost cause and the innovative history of health care in the state. Mississippi, we argue, is a place with something to contribute to the debates over global health, inequality, and innovative solutions. Considering the politics of knowledge production, Biehl and Petryna (2013, 15) ask: 'What or who must be valued in order for knowledge to count as global health science, and what or who remains subjacent or unaddressed?' In response, we offer the concept of epistemic prejudice, drawing attention to how people in certain privileged locations are valued to create generalizable knowledge in the global health landscape and how specific forms of innovation are silenced or not even recognized as innovative in the first place.

Yet this is a fine balance. We argue for the importance of health care innovations developed in Mississippi and emphasize that these innovations have been elided in much published literature in favor of a longstanding developmentalist narrative that emphasizes the role of outsiders coming in to help this poor, sick, and 'backward' place. In doing so, we try to avoid both a triumphalist narrative of singular innovation in an unexpected place or an overwhelming emphasis on the peculiarity of the place to the extent that innovations could not be generalized and implemented elsewhere. This is an ethnographic argument: one that points to local context, history, and political economy as crucial while emphasizing that this echoes similar stories in other contexts, notably elsewhere in the global South. In other words, we strive for neither tokenism nor blind boosterism. We seek to fully embed processes of health reform in Mississippi in broader national and international frameworks and trends, instead of emphasizing the peculiar and unique as somehow out of step with or outside of these processes. This reminds us of the denial of coevalness, and is subject to the same critiques (Fabian 1983).

We therefore argue for the importance of place in public health, following scholars in science and technology studies and critical medical anthropology. In particular, we follow David Livingstone (2003, 14), who argues that 'Place matters in the way scientific claims come to be regarded as true, in how theories are established and justified'. The case of community health centers (CHC) in Mississippi is the counter-example: when a place is not seen as authoritative, it often gets erased. This article contributes to the growing literature on how health interventions 'travel' and get made local, often intentionally, in a wide range of contexts, including Latin America, Papua New Guinea, Burkina Faso, Botswana, and Guatemala, among other locations (Cueto and Palmer 2014; Street 2014; Nguyen 2010; Livingston 2012; Yates-Doerr 2015). And we also situate ourselves within the strain of postcolonial science studies that critiques the dominant narrative of science and biomedicine as emanating from centers of political and economic power (the global North) and being applied elsewhere. This tension is illustrated in a *New York Times Magazine* article on

paleogenomics that describes the institutional and funding pressures that demarcate premier knowledge and scientific innovation as emanating from a few select genetics labs rather than in the field (Lewis-Kraus 2019). The postcolonial literature demonstrates the variegated ways that science and biomedicine are utilized, adapted, and innovated in places that are often thought of as postcolonial or in need of development (Seth 2009; Anderson 2002; Soto Laveaga 2009; Harding 2008). Our contribution here delineates how a case in the global North is reminiscent of such examples from the global South.

Below we develop our concept of epistemic prejudice by recounting stories of the CHC movement as an example of local innovation that is often ignored or dismissed. We then discuss representations of Mississippi in media and academic accounts that omit these cases, instead using inaccurate assumptions, to illustrate how epistemic prejudice can deny or silence innovation. Throughout, we explore how epistemic prejudice contributes to establishing facts about a place. We conclude with an extended discussion on the possible implications of epistemic prejudice and a few preliminary suggestions for how to combat it both within and outside of academia.

Thinking with/through ethnography

We are inspired by Biehl and Petryna's (2013) argument for ethnography in understanding health and formulating potential interventions to improving health disparities. Our methodological approach is informed by what Hugh Gusterson (1997, 116) calls 'polymorphous engagement', which utilizes an 'eclectic mix of other research techniques: formal interviews of the kind often done by journalists and political scientists; extensive reading of newspapers and official documents, and careful attention to popular culture'. Like Gusterson, we faced challenges in conducting traditional participant observation (of the long-term-residence-in-a-place kind) because of the sensitivity of health information and the dispersed nature of our research sites. We were, however, able to engage in other forms of participant observation for this study. As we are not only 'studying up' but also across time and space, our work is perhaps best understood as what Sherry Ortner (2010, 213) calls 'interface ethnography', which she defines as 'doing participant observation in the border areas where the closed community or organization or institution interfaces with the public'.

Our polymorphous engagement means that our data are drawn from diverse sources: online publications, journal articles, podcasts, speeches, and investigative documentaries. We also conducted participant observation in public or semipublic health care settings, and in heavily monitored and surveilled medical institutions ranging from major academic hospitals to rural community health clinics. Finally, we held numerous and diverse interviews and focus groups with physicians, patients, and health care workers, during both exploratory and

evaluation research projects over the course of several years. Notably, this is a collaborative project, with insights emerging in group meetings where we as authors discussed our evidence from across projects, compared our insights, and engaged in collective analysis. We are involved in community-based health research and community-university partnerships, and bring with us years of experience living and working in Mississippi. Because of the way we are trying to build theory, using examples from different historical time periods and sources, we need to utilize polymorphous engagement to better capture local processes.

In the end, we view this article as our ‘homework’ (Gusterson 2017) in order to understand the conditions of knowledge production in our specific context and how these conditions connect to regional, national, and global forms of value, prestige, and expertise. We argue that national and international markers of prestige flow in well-worn and sadly predictable channels: knowledge produced in locations that have been othered and by people excluded from power (due to race, class, region, gender) becomes invisible or easily dismissed by those in positions of national and global power. We use the term ‘epistemic prejudice’ to explain how this happens.

Defining epistemic prejudice

We define epistemic prejudice as a structural inability or resistance to seeing certain places, bodies, and locations as capable of knowledge production and innovation. This means that the generalizable validity and importance of interventions developed in contexts that are not globally powerful (in other words, in those locations often deemed ‘local’ in academic literature) are often denied.

Epistemic prejudice facilitates the process whereby assertions become taken-for-granted statements that do not need empirical support, operating essentially as facts. As such, epistemic prejudice is a kind of ‘ontological politics’, which Ivan da Costa Marques (2014, 85) defines as ‘choices and decisions that result in the establishment and stabilization or obduracy of frames of reference, which are the tools that people use to situate their engagements with the world (Callon 1998)’. We see this in our case, for instance, in the common comparison of Mississippi and Africa in popular media. This occurs with little attention paid to the details that undergird these assertions and their entanglement in broader sociopolitical forces, nor to the way these characterizations encode and reinforce racial stereotypes. In professional meetings and informal conversations, we have heard a recurring narrative that attributes Mississippi’s higher obesity trends to busy single mothers who, rather than cook at home for their children, choose convenience food, usually described as McDonald’s or fried chicken. Although race is not explicitly mentioned to us, fried foods have been traditionally associated with black communities in the South and are

often used to shame the health statistics of African Americans, though recently there has been renewed interest in countering this by promoting African diasporic foodways (Sankofa and Johnson-Taylor 2007; Twitty 2017; Edge 2017; Wallach 2015). Empirically we have not seen evidence that this simplistic maternal figure exists, especially to the extent that her individual choices would affect obesity trends at the population level (Chang and Lauderdale 2005; Gordon-Larsen, Adair, and Popkin 2003; Antin and Hunt 2012; Sturm and An 2014). The figure of the busy mother is serving as metonymic of a much broader trend, and encapsulates racist explanations, historical dismissals, and ungrounded answers. Using the concept of epistemic prejudice, we contend, helps to get at the roots of racial health disparities and potentially provides some insights to ameliorate them and other forms of inequality.

We argue that the challenges of addressing racial health disparities in Mississippi stem in part from epistemic prejudice on behalf of scholars, health care providers, and policy makers (both those within the state and outside of it) who often presuppose that since Mississippi is poor and sick, it will continue to be so without some significant intervention from outside. But recall Biehl and Petryna's (2013, 14) insight that 'local realities very much frame, constrain, and orient interventions'. In this sense, interventions aiming to improve health and quality of life in Mississippi must consider the capacity of local actors. But, as we have found among some medical and public health researchers in and outside the state, a narrative focused on lack rather than potentiality – as in, Mississippians do not have enough health resources, enough education, enough skills – which is very much a narrative we have heard before in developmentalist approaches to health elsewhere in the hemisphere (Cueto and Palmer 2014). This reflects an approach that has, until relatively recently, held sway in development efforts more generally, what William Easterly (2014) calls the 'Blank Slate mindset'. Experts, Easterly argues, view places of lack as 'infinitely malleable', ready for the application or imposition of often one-size-fits-all solutions crafted from outsider communities, presumably because these places offer no generalizable knowledge of their own. Relatedly, the 'developing world' is often homogenized in scholarship, whereby 'all poor countries seem equivalent' in their struggles and solutions (Easterly 2014, 25). Da Costa Marques (2014, 85) writes about the implications of such ontological politics: 'Western realities become "the reality" and other people's realities are considered merely different interpretations. ... The West has knowledge, while other people have mere beliefs'.

This might explain why Mississippi is frequently equated to countries in Africa or sometimes Asia. We go farther and suggest that this homogenization may even foreclose the possibility to analyze lack, inequality, and structural barriers in developed nations, explaining why, at the international level, stories from places like Mississippi have remained hidden and why, domestically, Mississippi is dismissed as a foreign country, or even worse than a foreign

country, because such conditions do not fit ideas about life in the developed world. Epistemic prejudice has implications for how we think about and approach deprivation in the United States.

Yet, many of the places targeted for outside intervention have produced their own movements of resilience from the bottom up. In particular the community health center (CHC) movement in Mississippi during the 1960s was a radical project that linked social justice, the amelioration of racial inequalities, and health care. We see epistemic prejudice in how this movement's history has until recently gone largely ignored in academic literature (deShazo 2018; Ward 2017). Without much information on current practices, challenges, and success stories, we are missing out on possible lessons to be learned for improving development and health efforts in Mississippi because epistemic prejudice forecloses the generalizable factors of specific local innovations: keeping them always 'local' versus authoritative knowledge.

Given that local voices continue to be dismissed, it is unlikely that policy, interventions, and research efforts will make much of an impact on health disparities. This is particularly important at a time when community-based and home-based medical models are being promoted as part of the solution to health problems. Analysts need to better understand how effective community-based approaches have been developed, and are still developing, in the global context of institutional and epistemological struggles for recognition (see Farmer et al. 2013). This is in part where our polymorphous engagement with the issues comes in – we need such nuances to understand how this happens on the ground.

Here, we focus on health as a way to explore epistemic prejudice of development more broadly because of its intimate connection with social justice movements and how this connection has been forgotten beyond Mississippi, thus providing empirical evidence for our concept. We examine the CHC movement, founded largely in Mississippi, as an instantiation of development that has generalizable implications. We argue that this case challenges assumptions about where knowledge originates and how it circulates around the globe. This case also illustrates how epistemic prejudice operates and it shows what can be gained from facing this form of prejudice.

Mississippi in the global South

Epistemic prejudice prevents us from crediting and institutionalizing innovation in Mississippi and elsewhere. For instance, as Ichiro Kawachi described in an interview:

There is a lot of attention on global health but basically, you don't need to go that far. ... Look in our backyard. I tell young, idealistic youth who want to make a contribution to global health that you don't have to go all the way to Malawi. You can do something in rural Mississippi. [Look at] Health centers like the one in Mound Bayou, MS, because basically it's the model of physician responsibility. (We Are Public Health 2014)

Kawachi calls on 'young, idealistic youth' to 'do something in rural Mississippi', with the implication that these idealistic health professionals would still be going somewhere different and exotic from their homes, to inform and to change this presumably unchanging place. This sounds an awful lot like older narratives of development expertise as flowing from North to South. We do not deny the profound inequalities between rural Mississippi and, say, the Upper East Side of Manhattan. And we share Kawachi's impulse to situate Mississippi within a global framework. It is in this vein we hope the concept of epistemic prejudice is an intervention in discussions about global health and health care disparities.

'Epistemic prejudice' builds on work in science studies and anthropology of knowledge, particularly Karin Knorr-Cetina's (1999; 2007) definition and exploration of epistemic cultures in knowledge fields. In particular, she emphasizes how they are tacit, almost embodied:

The notion of epistemic culture is designed to capture these interiorized processes knowledge creation. It refers to those sets of practices, arrangements and mechanisms bound together by necessity, affinity and historical coincidence which, in a given area of professional expertise, make up how we know what we know. Epistemic cultures are cultures of creating and warranting knowledge. This is what the choice of the term 'epistemic' rather than simply 'knowledge' suggests. (Knorr-Cetina 2007, 363)

It is this gradual process of consolidating facts about places and the unspoken, unacknowledged orientations and presuppositions about expertise, authority, and truth (and who gets to produce global Truth vs. local truths) that we are trying to get at with the concept of epistemic prejudice. Such prejudice is tacit, unexamined, powerful. It emerges in our literature analysis: Dr. Jack Geiger, a white physician from Tufts, often receives the most credit for the CHC movement in Mississippi, while politically active black physicians, including Dr. Aaron Shirley and Dr. Robert Smith, are rarely mentioned. Furthermore, the body of literature on Mississippi's present-day CHCs remains slim. We are therefore ignorant of their current challenges and successes. The impression created is that CHCs are artifacts of the 1960s that once happened in the context of the Civil Rights movement, as if the opportunity for social justice for Mississippi has come and gone. Alternately, they are

cast as extraordinary local institutions that cannot be generalized beyond their particular context or be innovative and influential in national and international settings. This, as we demonstrate below, is false.

It is our contention, then, that it has been via neocolonialist and residual paternalistic impulses, working within a colonial matrix of power, that much of the knowledge (taken-for-granted facts) about Mississippi's poverty and backwardness has been produced and reproduced (Mignolo 2011; Adams 1998; Trouillot 2003; Comaroff and Comaroff 2012). What does the casual dismissal of place (and not unrelatedly, its inhabitants) reveal about our still persistent 'untested assumptions'? What does our 'uneasiness' about the anthropological other being epistemologically equal (Fassin 2012, 106) say about race, poverty, equality, and contemporaneity? This dismissal – and the structure of knowledge production about Mississippi that recapitulates older narratives of colonialist science – indicates the continued relevance of racism, narratives of backwardness, and denial of agency for people cast as other to modernizing projects predicated on certain locations and bodies as the sites of authority. Epistemic prejudice thus blinds us – even those of us who are well-intentioned, critical, and should know better – to other ways of seeing place, and therefore other possibilities and potentialities for social justice, particularly paths toward ameliorating health problems.

Community health centers and South-South exchange

Mississippi was ground zero for the CHC movement during the Civil Rights era (deShazo 2018). Innovative, community-based clinics were established as a fundamental part of the struggle for civil rights. Talented, trailblazing physicians (often black and from Mississippi) worked in clinics across the state, providing comprehensive primary care and health education to residents who were often discriminated against or barred from accessing regional facilities. To become included in President Lyndon B. Johnson's War on Poverty policy initiative, CHCs were developed and institutionalized to provide comprehensive health care, including dental, vision, and mental health services to all individuals regardless of ability to pay (Ku et al. 2011). The structure and effect of CHCs later directly influenced the establishment of Federally Qualified Health Centers (FQHCs), which have since reshaped the landscape of care in the United States. The Patient Protection and Affordable Care Act appropriated US\$11 billion to expand the number of community health centers, which are considered a critical component to improving health care efficiency and effectiveness (Atsas and Kunz 2014).

Yet this legacy remains unexplored – an example of epistemic prejudice at work – despite CHCs' fundamental importance in shaping the contemporary health care landscape. For

instance, a plaque commemorating Mound Bayou as a community founded by freed slaves at the National Museum of African American History and Culture does not mention, however, it as the site of the founding CHC or the important work done by activists there. We argue this erasure occurs because Mississippi is seen as a place where knowledge and innovation cannot exist.

The CHC movement began, in part, in Mississippi during the 1960s because of politically active black physicians and health care providers working with other community organizers and residents. There is a broader story to tell about these organized coalitions who fought to establish and expand CHCs and made the amelioration of disparities a fundamental demand of the Civil Rights Movement; indeed, deShazo, Smith, and Skipworth (2014a, 921) write that they ‘changed both the course of history and the course of medicine in the United States’.

Here we outline a fuller narrative of the CHC movement to illustrate an example of innovation that has been obscured via epistemic prejudice. A great example of the power of collective action, the CHC movement stands as a testament to the determination of Mississippians, and as an instantiation of ‘theory from the South’ (Comaroff and Comaroff 2012), as this model was borrowed from South Africa, Mexico, and Iran (Bristol 2010), among others, all places seen at times as needing outside intervention, perhaps capable of local innovation but not anything generalizable.

CHCs in Mississippi arose from the intersections of several different development paths, including the international experiences of people involved in health and civil rights activities, free and low-cost clinics arising primarily in urban areas, and grassroots organizing and cooperative development initiatives in rural areas. Many historical analysts view the basis for the modern CHC arising from Columbia Point Health Center (now the Geiger-Gibson Community Health Center) in Massachusetts and the Tufts-Delta Health Center (now the Delta Health Center, Inc., DHC) in Mississippi. The organization of the DHC in 1965 in Mound Bayou was the outcome of numerous intersecting political and cultural forces, including a long history of community organizing (Dittmer 2009; Lefkowitz 2007), which began with former slaves from Joseph Davis’s Hurricane Plantation further south at Davis Bend. Following the end of the Civil War, former slaves and their descendants moved north into the Delta region, settling in Mound Bayou (Hermann 1999). Although it has since fallen on hard times, like many rural and previously agriculturally dependent communities, Mound Bayou was a highly successful black community with black-owned businesses, farms, a mill, a zoo, and eventually a swimming pool that, like beaches, otherwise remained inaccessible to African Americans in Mississippi (deShazo 2018; Mason 2000). Mound Bayou is also home to the Taborian Hospital, established prior to the DHC, which had its own prepaid health

insurance program (a precursor to HMOs) in 1942 (deShazo 2018). The Jackson-Hinds Comprehensive Health Center learned from and built on the Mound Bayou effort, this time in a more urbanized area (Dittmer 2009; Lefkowitz 2007).

At the time, the DHC model was unique in its focus on holistic health and comprehensive strategies (Dittmer 2009). In addition to writing prescriptions for food when patients were malnourished and helping install window screens in houses for people suffering from mosquito-borne illnesses, the DHC assisted with organizing a fifty-acre farm cooperative to produce vegetables and fruits for local consumption. In all, Dittmer (2009, 233) writes, it was a special, integrated approach to health, 'both for its time and ours. Where the traditional public health center dispenses pills and shots, at Mound Bayou the staff attacked the root causes of poor health and deprivation'.

Histories of the CHC and related movements are typically told in a fashion that highlights the important leadership of great individuals acting bravely and overcoming seemingly insurmountable obstacles. Much like histories of the Civil Rights Movement more broadly, the focus is often directed toward nationally known names, in this case, people like Dr. Jack Geiger and Dr. Count D. Gibson, many of whom were white activists who came to the South to give of themselves and contribute to the greater good. Indeed, most of the published literature detailing the practices of CHCs in Mississippi is limited to the history of the DHC's development, recorded by Geiger himself (Geiger 2002; Geiger 2005; Geiger 2016).

However, there are also stories of local and regional black heroes who made significant contributions in their own right, including James Anderson, L. C. Dorsey, John Hatch, Aaron Shirley, and Robert Smith. And there are other leaders, including those who merged the quest for social justice, economic opportunity, and health beyond the Mound Bayou and Jackson clinics, such as pharmacist Aaron E. Henry (who is the honorary namesake of a very successful CHC based in Clarksdale, MS, which is celebrating its fortieth anniversary in 2019); Dr. Douglas Connor who practiced in east Mississippi; Dr. Helen Barnes, the first black clinician hired as faculty at University of Mississippi Medical Center; and many others (Conner and Marszalek 1985; deShazo, Smith, and Skipworth 2014b; Ward 2017; deShazo 2018). These individuals are all from Mississippi.

Their personal narratives are necessary for learning about CHCs and the broader movements they were inspired by and helped to inspire. However, they are not sufficient, especially if we are to learn from contemporary medical and community efforts to improve health. To focus solely on key individuals is limiting in several ways. We often treat them and their stories as exceptions to the generalized rule that poor and often majority-black communities do not have much to offer in terms of solutions to broader social problems. Additionally, it is easy

to overlook the importance of the day-to-day practices required to create and maintain the sense of community and trust necessary to develop viable alternative systems. Focusing on just a few personalities negates the important yet difficult interactions between people and organizations within and outside the community necessary to collaboratively build the social and cultural capital, political and economic infrastructures, and policy mechanisms through which these alternatives can be sustained and scaled up for broader population level impacts. Finally, it is simple to see this work as something that happened in the past but that no longer continues today.² Epistemic prejudice in this example takes place through the elision of the individuals involved, the lack of awareness of the importance of these initiatives for poor communities of color and the violence that accompanied their implementation, and the downplaying of the profound impact that the struggle for civil rights has had on health care, including but not limited to movements for CHCs, Medicaid, Head Start, community health workers, and community-based primary care more broadly.

The CHC model offers us something large to learn from: the DHC is still in operation, having already celebrated fifty years. There are twenty-one CHCs in Mississippi and more than 1,200 nationally (many operating on multiple sites along with school-based clinics and mobile clinics) that are federally qualified and receive partial funding with bipartisan political support. Although the DHC and other CHCs have had their shares of ups and downs since the 1960s, and are sometimes critiqued for being too institutionalized, they continue to serve as a model of community-based, primary, patient-centered health care. And they have taken on new importance in the era of health care reform and the Affordable Care Act (Atsas and Kunz 2014). As deShazo, Smith, and Skipworth (2014a) note, the history of the DHC, including the roles played by many activist black physicians, is not simply about telling stories; these initiatives have changed US health care organizations and institutions by creating a model centered on preventative care; local provision of care; a holistic approach that included diet, physical activity, and mental health; and the work of health promoters and educators drawn from the community, a model that is also influential in Latin American social medicine (Cueto and Palmer 2014).

It is this combination of insiders, outsiders, and those somewhere in between (Kerstetter 2012) working collectively that has led to the development of alternatives. Epistemic prejudice, however, narrows analysts' focus such that they do not consider the various resources that diverse people and organizations bring to the initiatives. Jack Geiger did play a

2 A search of the PubMed database of Medical Subject Headings (MeSH) terms 'Mississippi' and 'community health services' yielded some articles written about CHC practices and policy, but only from the 1960s and 1970s.

fundamentally important role in the development of the DHC. But so too did local, everyday residents, farmers, civil rights organizations, and health care providers from around the state who were already in Mississippi before he arrived. Interestingly, their contributions have been recognized by Geiger, Shirley, Hatch, Smith, Henry, and others in their personal accounts (Dittmer 2009; Lefkowitz 2007; Geiger 2014; deShazo, Smith, and Skipworth 2014 a, b, c), though scholars have still to explore the implications of such efforts for health in Mississippi, with few exceptions. If one searches PubMed with MeSH terms ‘Mound Bayou’ and ‘community health center’, no results return. Expanding the search to ‘Mississippi’ and ‘community health center’ yields just sixteen results.³

Not enough research explores the current (and historic) practices of CHCs in Mississippi, especially given the persistence of racial health disparities they sought to alleviate. Still, there have been some qualitative research efforts to document current CHC practices in Mississippi. One of the authors of this article (Willoughby) conducted a month-long in-depth ethnographic study at a CHC located in the Mississippi Delta region, interviewing ten patients and thirteen staff members. This CHC had a majority African American staff serving a population that was also primarily African American. Willoughby found that, despite working in a challenging, resource-poor region, staff at this CHC took pride in their work, and they were respected by the patients they served. Similar interactions were observed through Green’s experience working at the same CHC in a multiyear program aimed at reducing poor birth outcomes and expanding supportive services for families when a baby has been hospitalized hours away in an urban neonatal intensive care unit. Patients valued this CHC as a stable and reliable source of knowledge and support within larger political, economic, and day-to-day contexts of uncertainty. As one patient said, ‘The Lord brought us Dr. Thompson’ (name changed).

The racial concordance between patients and providers in this health care setting delivery is crucially significant in Mississippi. During segregation, black patients were subjected to poor standards of care, if not denied treatment; black physicians were denied membership to the American Medical Association, thus barring them from employment as licensed practitioners; and Southern governors created scholarships encouraging black medical students to attend out-of-state historically black colleges, including Meharry and Howard, by way of avoiding integration in Southern medical schools (deShazo et al. 2013). CHCs emerged responding to this repressive health care system, as well as to implement a new and less hierarchical model of care.

3 A 2016 search of PubMed, repeated in 2019, yielded the same results.

The positive impact that the above-mentioned CHC continues to have on the community in which it is located is crucial to understanding the on-going innovation in health care that CHCs represent in underserved areas. However, hard-won CHCs are vulnerable to structural pressures in the health care system. Another author (Centellas), who interviewed some of the pioneering physicians in the CHC movement or their children, along with conducting site visits and observations in health care settings, heard in more than one interview that these health practitioners or their families were dismayed that the health disparities, which are deeply linked to race and income, still persist forty years later. This person, intimately familiar with the struggles faced by the pioneering activist physicians, connected the lack of improvement to a trend in the commodification of health care, as health care and CHCs are seen less as fundamental components of a broader campaign for rights and equality. She cited an example of a hospital in an urban area that included a health center primarily staffed by and serving African Americans. After the hospital was acquired by a for-profit health care corporation, the community clinic was shuttered. In her understanding, the closure occurred because the center was 'too successful' at managing chronic conditions, and thus reduced admissions, and revenue, for the hospital. The lens of epistemic prejudice can help us understand why, beyond sheer profit taking, this successful health center was closed: successful local interventions were not prioritized or acknowledged, and different (in other words, economics vs. social justice) logics governed decision-making. Our ethnographic data indicate that incorporating lessons from long struggles for social justice, and taking seriously local voices and knowledge generated on-the-ground in health care delivery can improve health. Not acknowledging these leads to a kind of reinvention of the wheel: the results are more of the same, studies are superficial, and peoples' desires and voices are silenced.

Mississippi, deemed a place of spectacle and disgust

Why has there been relatively little attention paid to the CHC movement as innovative and transformative on its own terms? We argue that it is, in part, due to epistemic prejudice, a way of denying agency and expertise if it comes from outside of global centers of knowledge production. Returning to the examples in the introduction, the trope of analogizing Mississippi to Africa or Latin America both distances Mississippi from the global North and the United States in general, and casts it as incredibly local and particular. As in the stereotypes of African countries, Mississippi is written of as a place we fail to learn from and fail to contribute to successfully. More to the point, Mississippi is often seen as a place where outside knowledge is required, not as a place from which knowledge flows. But, as we argue above, this is inaccurate and likely a result of epistemic prejudice. And, we suggest, this is also inflected by race. More than one-third of Mississippi's population identifies as black or African American (and a majority of the people in the Delta region do so), and it is perhaps not a coincidence that public discourse often compares social, health, and economic

circumstances between black populations around the globe. Yet this overly simplifies the relationships between race and geography, and ignores the systematic, race-based discrimination in the United States.

A clear bias against Mississippi appears in popular media about health and social problems as iterations of lack. In an attempt to gain a broad understanding of Mississippi's health challenges, we conducted Google searches for stories on specific topics, including infant mortality and obesity, over the course of several weeks in 2016. Additionally, large media sources, including *The Atlantic*, *The New York Times*, *Vox*, *Slate*, and *NPR*, were selected and searched for articles related to Mississippians' health. The following content analysis does not aim to be exhaustive but rather selects several remarkable pieces from well-known media sources to stimulate further discussion on the ways that epistemic prejudice may operate in our understanding of Mississippi's health problems. They reflect the general narrative of Mississippi's portrayal in media, of which there are countless results.

Pieces were also selected for their efforts to compare the Mississippi context to others more traditionally positioned as in the global South, such as an article published in *The Atlantic* entitled 'Paying Teens Not to Have Sex: What Mississippi Can Learn from Malawi' (Ganguli 2013). Paralleling Malawi's and Mississippi's high teen pregnancy and child poverty rates, the author predicts that conditional cash transfers should work in Mississippi, given the success in Malawi. But is this sufficient enough to inform the Mississippi context? Even still – and the author admits – Mississippi's teen pregnancy rate is much lower than Malawi's, at 55 per 1,000 births compared to Malawi's 177 per 1,000 births, and like other states it has declined in recent years. So why compare the two places? While there might be some merit to the author's effort to link South-South practices, these are very tenuous connections, with the structural factors making them similar left unspecified. Mississippi's high teenage pregnancy likely exists for different reasons than Malawi's. The author does not discuss racial disparities, violence against women, lack of access to health care and birth control methods, social norms, and a failing education system, all of which persist in Mississippi, within a developed world context. This move is an inversion of what one of us has termed the 'construction of equivalency' (Centellas 2014) between South-South nations for political purposes; here we see Mississippi being equated with (and therefore exoticized and othered like) Malawi, and not contextualized as within the southern United States.

Writers may even use inaccurate data to help prove their point. In an *Al Jazeera* piece entitled 'Mississippi's Lost Babies' (Hasselle 2015), the author claims to 'explain why black infant death (in Mississippi) outpaces Botswana', stating Botswana's infant mortality rate is 8.9 per 1,000 live births while Mississippi's black infant mortality rate is 11.2. Upon further research, however, we found that these data were wrong. Botswana's infant mortality rate was much higher, at 34.8, corresponding to its equally high maternal mortality rate (World Bank Open

Data 2015). Yet this journalistic ‘fact’ has gone uncontested. This is epistemic prejudice at work, as casual claims that play into a narrative about a place are reiterated and accepted, inevitably becoming truth.

This uninterrogated authority is repeated in the many op-eds, exposés, and feature stories that all seek to ‘understand’ a place like Mississippi. Yet we see exoticization by way of expected imagery, even from well-intentioned high-caliber journalists. In a video production by *NPR* and *Oxford American* (Elliot 2011), viewers are taken to Holmes County, commonly regarded as ‘ground zero’ for the obesity epidemic, to answer the question, ‘What makes bad food so good?’ Rather than address a myriad of factors that may (or may not) contribute to high obesity rates in Holmes County, the producers play on tropes by showing hot pans of fried chicken, worn-down houses, and empty roads. In print media, a recurring photograph of a man (Tama 2009) working at a shop counter, with shelves of chips, dried goods, and vintage cigarette advertisements assorted behind him, appears alongside various commentaries on the state’s poverty in *Slate* (Bouie 2014), *NPR* (Husted 2011), and *Vox* (Matthews 2015).

How does using such iconic imagery come to shape our understanding of a place? How does this influence the questions we ask, or do not think to ask? This media lacks dynamism. It portrays the Delta (and Mississippi) as a disparaging stereotype that will never be fully understood. This is how epistemic prejudice comes to fruition. A *Vox* article summarizes: ‘Everything that we found in other places was magnified and maybe a decade more advanced in the Mississippi Delta. The place is really a world apart. The difference is that whole systems were failing people’ (Matthews 2015).

It is peculiar that Mississippi is frequently compared to countries, rather than other depressed regions within wealthy nations, or even other marginalized regions within the United States, such as rural Appalachia, Native American reservations, and Hispanic migrant communities, or blighted inner cities, though these places face similar problems related to chronic disease and deep poverty. In media representations, we find that there is little discussion of the political and structural reasons why Mississippi is the way it is, within such a highly developed nation; from the academic community, we also miss any discussion of why and how we continue to conceptualize Mississippi as an irredeemable other. To let these representations go uncontested presumes an acceptance of epistemic prejudice toward such places from audiences at large.

Appalachia is not always written about in the same way as the Mississippi Delta, a historically black region wrought by slavery and its legacy. The contrast is evident as a *USA Today* headline declares, ‘What Ails Appalachia Ails the Nation’ (Ungar 2014). In this article, the

author makes no reference to developing countries, nor to Africa. Instead, Appalachian problems are American problems: ‘Some experts worry what’s happening there could be a harbinger of what is in store for the USA as a whole if disturbing trends, such as rising obesity, don’t change’ (Ungar 2014). Most recently, experts and mainstream audiences alike have rallied together to understand the underlying factors contributing to the US opioid epidemic, and the structural inequities that have encouraged the rise of nationalism and populism in and after the 2016 presidential election. Much sympathy has been expressed for America’s troubled, left behind, working-class whites. But what, we ask, about left behind, working-class black communities?

Yes, some parts of Mississippi do share the statistics of developing countries, but casually making these comparisons without substantial research behind them does nothing to help the people of Mississippi. Mississippi is not a country; it is part of the United States, which is still responsible for the systems that are ‘failing people’. But if it is portrayed as a ‘world apart’, the rest of the nation might try to justify writing off Mississippi. An epistemic prejudice to seeing a place as incapable of producing knowledge, we contend, allows journalists to conflate sparse (or inaccurate) data and anecdotes into grand, unfounded statements about a place. They do not feel compelled to check such data with local experts. Epistemic prejudice allows writers, policy makers, and physicians to ‘understand’ Mississippi in any way they want. Often, they understand it by dismissing it or just wringing their hands over the lack of solutions.

Richard Grant, author of the praised *Dispatches from Pluto* and much respected for bringing tales from Mississippi to a national audience, does at times engage in this same problematic thinking in his poetic descriptions of the Delta: ‘a dysfunctional third world society in the heart of America’, with ‘crumbling towns and black rural poverty reminiscent of Haiti’ (Grant 2015). Again, outsider knowledge is taken as authoritative, aided by epistemic prejudice that proclaims Mississippi as other. Here it is equated to Haiti; at other times, Malawi, Botswana, and Bangladesh.⁴ Epistemic prejudice in this case not only illustrates how certain places are perceived as incapable of producing knowledge but also how they are subject to unwarranted criticism, for example, as basket cases, as if that diagnosis is enough without further analysis. Thus emerges a story about a place so different, so eccentric, so

4 A *Bloomberg* article is entitled, ‘How Mississippi Is Worse Off Than Bangladesh’ (Fox 2017). When interviewed for *The Atlantic*, Nobel laureate and economist Sir Angus Deaton commented on global income inequality, ‘Part of it is you throw up your hands and say poverty is very complicated and you can’t make these international comparisons! But if you had to choose between living in a poor village in India and living in the Mississippi Delta or in a suburb of Milwaukee in a trailer park, I’m not sure who would have the better life’ (Lowrey 2017).

particular that there is no lesson, no understanding, no knowledge that could be drawn from it to inform broader analyses of social processes. Mississippi becomes a thing in and of itself, disconnected from other places and practices except by pat comparisons based mainly on the racial makeup of the population. The directionality of knowledge production is foreclosed.⁵

In need of expert (outsider) intervention?

In these media representations, those speaking from the outside eagerly offer their opinion to Mississippi, about its affairs and needed solutions, as if these are obvious and easy to implement. And, they do so as if Mississippi itself was, and had chosen to be, ignorant of its problems. This approach has been similarly critiqued in the development community, but, again, generally in contexts of the global South (Easterly 2014; Munk 2014; Jerven 2015). As a result, real institutional barriers within the state that prevent development/promote underdevelopment, including an entrenched legacy of conservative politicians, corruption, and outmigration of educated young adults, are not considered.

The media narratives all note the disenfranchisement of populations, but how do they function to continue disenfranchising those who are spoken about, and not adequately represented? We see minimal acknowledgement of the innovations and knowledge produced here, even after struggle for recognition. What can such deeply engrained epistemic prejudice do to shape how we learn about a place, and how we go about changing it (or not)? The media examples we present here matter, as the media is everywhere. It has an impact on how we ask questions about places of lack, how we frame these questions, how we research or do not research places of lack, and, therefore, what we will or will not do about these places of lack.

Why are comparisons between Mississippi and African countries believable? Why are such erroneous statistics plausible, when a little digging uncovers their inaccuracy and inadequacy? We have found relatively few studies exploring health care disparities in Mississippi beyond epidemiological surveillance. For instance, a PubMed search using MeSH terms ‘Mississippi’ and ‘healthcare disparities’ yielded seventy-one articles, of which very few address policy-related factors that may contribute to disparate health outcomes, mechanisms for change, or CHC practices or other innovative solutions in the state. These are critiques of public health literature more broadly. However, we find this particularly offensive, when Mississippi is so

5 It is worth noting that in this case Mississippi is summarized as the small town of Pluto, also coincidentally as far out in the solar system as one can get.

often dismissed as a place of lack but so little research is being published to show the extent of this lack (how, where, and why), or evidence of ways to counter it.

These few studies tend to focus on African American populations in the Delta, with a deterministic voice that reminds us of colonialist anthropological writing, predicated as it was on a static, unchanging model of culture (cf. Fabian 1983):

The level of understanding of the meaning of health among this population, particularly as it relates to the concept of energy balance, is superficial. Our findings show a strong culture of overeating, in which there is tremendous pride. Food is even sometimes used as a form of self-medication for the depressed psychological moods associated with low self-esteem and loneliness. Our findings also reveal a lack of information on how to prepare healthy meals and how to increase physical activity in a resource-constrained environment. (Parham and Scarinci 2007, 5).

We argue that there is still much to be researched on health disparities in Mississippi. The current body of literature is not sufficient, as it mainly focuses on the prevalence of illnesses and disparities in outcomes, and at times relies on culturally deterministic explanations. It is likely that funding, politics, or other institutional barriers are preventing this research, but we see in these barriers as another instantiation of epistemic prejudice.

The identification of health problems and development of strategies for improving health from the grassroots level is easy to celebrate in the abstract sense. However, to take these initiatives seriously and learn from them requires greater commitment. As Robert Chambers (1997) points out, we – those of us involved in professional work as leaders, researchers, and/or practitioners – are often part of the problem faced by the poorest and most vulnerable people. A deep commitment to epistemic equity is not just a matter of decision-making structures or methods of research; it is also an issue of vision and what might cloud that vision.

Epistemic prejudice influences what we see and therefore what we think about what we see. This applies to how we view the development of community-based health programs arising from the very places that appear to be in the greatest need. Do we dismiss them, or perhaps treat them as unique exceptions to the general rule, from which nothing noteworthy can come? We argue that we should broaden our understanding of where generalizable knowledge comes from to counter this orientation.

Conclusion

By and large, the narrative on the state of affairs in Mississippi and the Delta, specifically in regard to health, revolves around poverty and poor education. Rarely are the larger social, political, economic, and even environmental contexts explored in Mississippi's health care literature. Not understanding the systemic challenges faced by Mississippians, and failing to recognize and learn from responses arising from community-based collective action (such as those in the Delta and the CHC movement), limits our knowledge. And while the Delta region is frequently compared to underdeveloped African countries, these comparisons tend to be superficial and biased, collapsing complexity. We argue that this is a manifestation of epistemic prejudice, which serves to perpetuate a shallow understanding of the root causes of health disparities and social inequality, instead of recognizing local knowledge and innovation as epistemologically equal and formulating solutions from that knowledge base. More broadly, the dismissal of some places as unable to produce generalizable knowledge can exacerbate inequality. The concept of epistemic prejudice helps us understand how this is possible – even among otherwise careful and thoughtful practitioners – and gives us an analytic path forward to generate better empirically grounded research.

Furthermore, understanding how public and academic communities engage with statistics and perceive the health of the state is crucial for those programs, policies, and practitioners addressing these issues. What are the overall goals of this rhetoric? What does it wish to achieve, or serve to do? And why do such characterizations in the media go uncontested? Why is it acceptable or accepted as fact? Even though there are numerous community-based organizations in the Delta region and throughout the state of Mississippi focusing on access to fresh produce, health education, and health care, tales of collective action rarely make it into mainstream dialogue. And, accordingly, their real institutional struggles often continue without the interest that they do need from scholars, media, and organizations from outside the state. What we think we know about health problems and solutions in Mississippi may not be entirely accurate, due in part to this epistemic prejudice. We seem to have an almost-tautological feedback loop between media representations and research design, which can function to close off future research directions as unthinkable or impossible. This does a disservice to researchers and people living in Mississippi and elsewhere. More crucially, it reveals still-dominant neocolonial and racist hierarchies of prestige and power.

This is where the contrast between the accepted narrative of the development of CHCs and the unwritten history of the complex interplay of activist physicians and holistic development approaches in the midst of the bloody struggle for civil rights (including health care) is illuminating. Considering the importance of CHCs (and the concomitant development of FQHCs) to health care throughout the United States, it is crucial to

understand the complex ways in which they developed and are developing. Somehow the work of civil rights activists, and of those people and organizations working on the front lines since, has been overall forgotten. And it is this forgetting – and the surprising myopia and reliance on neocolonialist, racist, and/or paternalistic assumptions about the people here – that we are attempting to address with the concept of epistemic prejudice. Acknowledging such prejudice can help us chart a path forward, with careful attention to insights from critical development and South-South models of collaboration, to look for local innovative models to ameliorate health disparities.

Of course, epistemic prejudice has implications beyond health care, most notably in politics. If we return to the observation that some assertions become taken-for-granted facts, then the concept of epistemic prejudice can help unravel why this happens. And it may also help us understand how readily some can use a term like ‘fake news’ or ‘alternative facts’. We urge scholars and practitioners to take such assertions seriously and carefully consider the ontological terrain they reveal. This is not the same as saying facts are impossible, but some of our beliefs, which operate as facts are, in truth, not empirically grounded. These can be so tenacious as to require significant cognitive (and perhaps affective) work to overcome, so much so that evidence to the contrary is often silenced (cf. Trouillot) and dismissed.

While our arguments likely resonate with Southerners, they are not exclusively for them. These stories from Mississippi have something to offer for the rest of the world, not only about the spectacle of the other but also about struggle, perseverance, and resilience. The questions we have raised here illustrate the imperative of this type of research for improving health outcomes and social disparities in places and among populations of lack. The current approach, one that denigrates the people living in certain locations and dismisses their innovations, is clearly ineffective and is linked to long histories of universalizing certain kinds of knowledge while dismissing or ignoring others. And perhaps it is intentionally designed this way. If we continue to ignore or fail to identify real development needs and opportunities, we are missing out on pathways for improvement. We challenge researchers, journalists, policy makers, and particularly health practitioners to begin critically evaluating the health research landscape of Mississippi, and to question how epistemic prejudice may cloud our understanding of a place. To deny recognition of local innovation only endangers our chances for social justice.

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