Reviews

Marissa Mika, *Africanizing Oncology: creativity, crisis, and cancer in Uganda*. Athens OH: Ohio University Press (hb US$80 – 978 0 8214 2465 0; pb US$34.95 – 978 0 8214 2509 1). 2021, 260 pp.

Marissa Mika's *Africanizing Oncology* tells the surprising story of the founding and trajectory of the Uganda Cancer Institute (UCI). She answers the book's central question, 'How did Ugandans Africanize oncology?' (p. 12), by charting the history of this centre of excellence and the global network of partners, funders and researchers that cemented biomedical oncology practice in Uganda.

Mika contrasts her historically rooted ethnography with much of the medical anthropology and science and technology studies (STS) scholarship on biomedical practice in Africa. She notes that such scholarship is often written through a lens of scarcity, which describes a lack of resources as driven by the pernicious forces of structural adjustment and market-oriented neoliberal reform imposed from the global North. Instead, *Africanizing Oncology* 'offers a necessary and long-overdue opportunity to situate Africans at the center rather than the periphery of biomedical knowledge production as researchers, physicians, administrators, patients, caretakers, and laboratory technicians' (p. 11). Through detailed analysis of fifty-plus years of historical record, wide-ranging interviews with the living protagonists and years of ethnographic involvement with the UCI, Mika traces the 'oscillations of fortune, waxing and waning resources, and epidemics [that] have all impacted the scale, quality, and scope of biomedical care in Uganda ... [and] allows a longer view of the material stakes, creative practice, and lived experience of biomedicine in East Africa' (p. 11).

Mika's account of expanding cancer care in Uganda contributes to our thinking on how the production of transnationally valued scientific knowledge about cancer – particularly early studies of promising new cytotoxic drugs (chemotherapies) on Burkitt lymphoma and other tumours – required significant material investments in clinical and human infrastructure necessary for the delivery of effective *care*. She writes: 'To conduct systemic clinical trials on Burkitt's lymphoma, the built and human infrastructure to facilitate the movement of patients, drug therapies, statistics, funds, and knowledge in cancer research would need to be actively made. They would need to create an entire cancer hospital' (p. 41).

The global and local political economy shifted dramatically around the Mulago National Referral Hospital and the UCI during this period: a devastating civil war and misrule by Uganda's dictator, Idi Amin, in the 1970s; public disinvestment due to the fallout of imposed structural adjustment policies in the 1980s and 1990s; and the rise of global health research and investment driven by the political interests of HIV exceptionalism in the mid-2000s to the mid-2010s.[1] By centring physician-researchers, especially Ugandans, committed to protecting the UCI's

[1] A. Benton (2015) *HIV Exceptionalism: development through disease in Sierra Leone*. Minneapolis MN: University of Minnesota Press.

continued programmatic efforts to deliver effective care for patients, Mika highlights the creativity and ingenuity necessary to refashion 'the resources and oncological technologies brought through transnational cancer research partnerships to meet the needs of Ugandan cancer patients and their caretakers' (p. 9). This is what she means by *Africanizing Oncology*.

Conceptually, Mika deploys the term 'experimental infrastructure' 'to describe the constellation of physical facilities, research questions, care practices, data collection procedures, and human labor that makes research and care function on a day-to-day basis at the Uganda Cancer Institute' (p. 10). This framing and up-close analysis of experimental infrastructures, along with their contingent socio-material practices, are important for understanding the space of constrained possibility that characterizes the day-to-day work of Ugandan physicians, nurses, community health workers and researchers.

If 'research is our resource', as the UCI slogan goes (p. 9), what does this say about a global health political economy that values certain experimental infrastructures over others? This case opens a more general question: how does global public health and biomedical knowledge get constructed and travel in a world riven by extreme inequality? What are the arrangements that enable anomalous healthcare delivery practices (the construction and maintenance of novel demonstration programmes, centres of excellence, extraordinary case examples, etc.) such as the UCI to serve as 'epistemic hinges'[2] capable of translating local experience into *evidence*, and evidence into extra-local (or global) *justifications* and demands for material redistribution for care delivery? More historically deep and geographically broad case studies like this one are important sites of social-scientific research. They are diagnostic of a broader field of symbolic and material struggle and can shed light on contemporary efforts to decolonize global health.

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In a recent series, *The Lancet Global Health* published a collection of responses to the question 'What is wrong with global health?' Commentaries identified numerous challenges and inequalities that have long plagued the field. The story of the Uganda Cancer Institute (UCI) chronicled in Marissa Mika's *Africanizing Oncology* takes a

[2] M. S. Morgan (2012) 'Case studies: one observation or many? Justification or discovery?', *Philosophy of Science* 79 (5): 667–77; L. de Souza Leão and G. Eyal (2019) 'The rise of randomized controlled trials (RCTs) in international development in historical perspective', *Theory and Society* 48: 383–418.