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Cultural Framings of Cancer: Medical Anthropology on Narrative Intertextuality, Immunotherapeutic Integration, and Neoliberal Resource Conflicts

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ABSTRACT

This medical anthropological study aims to explore the cultural framings of cancer in urban settings, focusing on narrative intertextuality, immunotherapeutic integration, and neoliberal resource conflicts, to understand their impact on health experiences in a globalized context. Through a descriptive synthesis of secondary data—drawn from ethnographic studies, biomedical reviews, and policy reports—it examines how communities in cities like Mumbai, São Paulo, Chicago, and Nairobi construct cancer meanings, integrate biomedical treatments with traditional healing practices, and navigate systemic inequities. The methodology involved selecting peer-reviewed sources from 2000 to 2023 via databases like PubMed and JSTOR, using narrative synthesis and thematic analysis to identify key themes across global North and South urban contexts.Key findings reveal cancer as a contested phenomenon: intertextual narratives frame it as a “divine test” in São Paulo or a “modern affliction” in Nairobi, creating tensions with biomedical approaches like

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immunotherapy, often seen as foreign. Neoliberal health policies exacerbate resource conflicts, limiting access for low-income groups in Mumbai's slums and Chicago's underserved areas. Urban communities show resilience by integrating pluralistic practices—e.g., Ayurveda with chemotherapy in India or spiritual rituals with hospital care in Brazil—though cultural misunderstandings and economic barriers persist. The study advocates for culturally sensitive, equitable interventions, emphasizing bridging biomedical and traditional ontologies through trained providers and policy reforms. Contributing to medical anthropology, it offers interdisciplinary insights into cancer care, providing actionable recommendations—such as subsidizing immunotherapies and employing cultural mediators—to address conflicts and foster integration.

Keywords: Medical Anthropology; Cancer Narratives; Cultural Ontologies; Biomedical Immunotherapy; Socioeconomic Disparities; Conflict and Integration

1. Introduction

Cancer, a global health crisis, transcends its biological origins to become a profound sociocultural, scientific, and economic phenomenon that shapes human experience across diverse urban landscapes [1]. In the contemporary era of globalization, marked by rapid urbanization, technological innovation, and the pervasive influence of neoliberal health policies, cancer is not merely a disease but a cultural artifact imbued with symbolic meanings, a biomedical challenge pushing the boundaries of scientific innovation, and an economic burden exacerbating inequities in transnational healthcare systems [1]. Medical anthropology, with its interdisciplinary approach, offers a critical lens to explore these multifaceted dimensions, weaving together ethnographic insights, biomedical analyses, and political-economic critiques [2]. This article embarks on a descriptive inquiry into the cultural ontologies of malignant transformation, examining how cancer is narrated, treated, and constrained within the complex health ecologies of globalized urban centers [1,3]. By synthesizing intertextual cancer narratives [4], biomedical immunotherapeutic paradigms [5], and political-economic analyses of resource allocation [6], this study seeks to illuminate the lived realities of cancer in the context of neoliberal globalization, ultimately advocating for health interventions that are both culturally sensitive and equitable [1].

The cultural dimensions of cancer are deeply rooted in the ways communities narrate and interpret the disease [1], reflecting both universal anxieties and localized cosmologies. In urban settings across the global South, such as the sprawling slums of Mumbai, the favelas of São Paulo, or the informal settlements of Nairobi, cancer is often metaphorized in ways that resonate with cultural frameworks of morality, spirituality, and social transformation [1,7]. It may be described as an "invader" disrupting bodily harmony, a "silent thief" stealing life without warning, or a "modern curse" linked to the perceived moral decay of urban life. These intertextual narratives [4], as theories of stigma suggest [8], position cancer as a social phenomenon that disrupts individual identities and community cohesion, often leading to social exclusion or marginalization [1]. Ethnographic accounts from global South megacities reveal how cancer patients navigate pluralistic health systems [1,9], blending biomedical interventions with spiritual healing practices or traditional remedies. For instance, in urban India, cancer might be attributed to karmic imbalances, prompting patients to seek Ayurvedic treatments alongside chemotherapy, while in urban Brazil, Pentecostal communities may frame cancer as a divine test, integrating prayer and ritual into their healing journeys [1,10]. These cultural ontologies, which refer to the ways communities conceptualize existence and illness, highlight cancer's embeddedness in symbolic discourses that challenge the biomedical tendency to reduce the disease to mere cellular dysfunction [1,3,11]. Symbolic anthropology, with its focus on rituals, meanings, and cultural symbols, provides a robust theoretical framework to analyze these narratives, revealing how they mediate experiences of suffering, hope, and resilience in urban contexts [4,12].

Beyond its symbolic significance, cancer also engages with the material realities of urban life, where diverse healing systems intersect and often compete [1]. Medical anthropology's emphasis on medical pluralism underscores the coexistence of biomedical and alternative healing practices, particularly in global South cities where

access to formal healthcare is uneven [2,13]. For example, in urban Nigeria, patients might consult both oncologists and traditional healers, using herbal remedies to complement radiotherapy [9], reflecting a pragmatic approach to health-seeking behavior [14]. Such practices are not merely additive but reflect deep cultural negotiations, where cancer is understood through lenses of ancestral knowledge, spiritual balance, and community support [1]. Anthropological theories of embodiment further enrich this analysis [15], emphasizing how cancer is experienced not just as a biological condition but as a lived, embodied reality shaped by cultural and social forces [1]. In urban contexts, where migration and cultural hybridity are common, these embodied experiences of cancer are further complicated by the intersection of global biomedical discourses and local healing traditions [1], creating a dynamic interplay that medical anthropology is uniquely positioned to explore [2]. Moreover, postcolonial perspectives highlight how colonial legacies continue to shape health practices in urban settings [16], with biomedical systems often perceived as extensions of Western dominance, prompting resistance or reinterpretation through local frameworks.

Biomedically, cancer represents a frontier of scientific innovation, yet its advancements often reveal cultural and economic fault lines [1]. The emergence of immunotherapeutic paradigms [5], such as immune checkpoint inhibitors and chimeric antigen receptor (CAR) T-cell therapies, has transformed oncology [17], offering targeted treatments for cancers like melanoma, lymphoma, and certain leukemias. These therapies, which leverage the body's immune system to combat cancer [1], are grounded in an understanding of its molecular pathobiology [18], hallmarks such as uncontrolled cellular proliferation, angiogenesis, and immune evasion. While these advancements promise precision and improved outcomes, they remain largely inaccessible to many urban populations, particularly in the global South, due to their high costs and the specialized infrastructure required for their administration [19]. In medical anthropology [2], the concept of medical pluralism highlights how such biomedical innovations coexist with alternative healing systems [13], often leading to tensions. Urban patients in cities like Manila or Johannesburg may view immunotherapy with skepticism [5,9], associating it with foreignness, expense, or potential side effects, while preferring local practices such as herbalism or spiritual healing [14]. This skepticism is not merely a rejection of biomedicine but a reflection of cultural values and economic realities that shape health-seeking behaviors. Anthropological studies of science and technology offer a framework to examine these biomedical paradigms as culturally situated discourses, revealing how they intersect with patients' lived experiences and the broader social contexts of urban health systems [5,20].

The evolution of cancer treatment further underscores these cultural and economic divides [1]. From the era of cytotoxic chemotherapy, which often caused severe side effects, to the current focus on immunotherapy and precision medicine, biomedical advancements have shifted the paradigm of cancer care [1,5]. Yet, as global health scholars note [21], these innovations are unevenly distributed, with urban populations in the global North often benefiting first, while those in the global South face delays in access due to systemic barriers. For instance, CAR T-cell therapies, which can cost upwards of $400,000 per treatment, are rarely available in low-resource settings, leaving patients to rely on older, less effective treatments or alternative therapies [9,22]. This disparity highlights the need to contextualize biomedical advancements within the framework of urban health pluralism [13], where access, acceptance, and cultural relevance vary widely. Medical anthropology contributes to this discourse by examining how patients negotiate these biomedical options within their cultural and economic constraints, often reinterpreting scientific interventions through the lens of local knowledge systems [2,9,11]. Additionally, feminist anthropology brings attention to gendered dimensions of cancer care [1,23], noting how women in urban settings may face additional barriers, such as caregiving responsibilities or lack of access to female-specific cancer screenings, that further complicate their health-seeking behaviors. By tracing the historical and cultural trajectories of cancer treatment [1], this article situates immunotherapy within a broader narrative of medical innovation and cultural adaptation, emphasizing the need for approaches that bridge scientific progress with cultural sensitivity [5].

Economically, cancer care is profoundly shaped by neoliberal transnational health governance structures [1,19], which prioritize market-driven models over equitable ac-

cess, exacerbating disparities in urban settings. Neoliberalism, as a dominant global economic framework, restructures healthcare through privatization, cost-shifting, and reduced public funding, often placing the burden of care on individuals rather than systems [24]. In global South cities like Nairobi, public hospitals are frequently overcrowded and under-resourced, forcing cancer patients to seek treatment in costly private clinics or forego care altogether [9,25]. The economic burden of cancer, including direct costs like treatment and indirect costs like lost productivity, disproportionately affects low-income urban populations, where out-of-pocket expenses can lead to catastrophic expenditure [1,26]. Political-economic analyses, drawing on the concept of structural violence, and as Jamalpour et al. believe psychosocial stressors and gendered experiences [6,27], reveal how these disparities are embedded in global health policies that prioritize profit over equity [19]. For example, the high cost of immunotherapies reflects a pharmaceutical industry driven by market incentives, often neglecting the needs of low-income urban populations [5,28]. In the global North, similar inequities persist, particularly among urban minorities. In cities like Chicago, African American communities face delays in cancer screening due to systemic racism, economic marginalization, and lack of access to quality healthcare [1,15], illustrating how structural violence, and psychosocial stressors and gendered experiences operate across global contexts [27].

These economic disparities are further compounded by the social determinants of health, which shape cancer outcomes in urban settings. Social epidemiology highlights how factors like poverty, education, and housing influence cancer incidence and survival, with urban poor populations bearing the brunt of these inequities [29]. In cities like São Paulo, where informal settlements lack basic sanitation, environmental exposures to carcinogens, such as air pollution or contaminated water, may increase cancer risk [1], yet access to screening and treatment remains limited [30]. Political-economic frameworks critique the neoliberal structures that perpetuate these inequities [6,24], arguing that health policies must address the root causes of disparity rather than focusing solely on individual behaviors. Medical anthropology extends this critique by examining how urban populations experience these economic constraints, often navigating them through community-based strategies or alternative healing systems [2,9]. For instance, in urban Mexico, community health networks may provide emotional and financial support to cancer patients [1], mitigating some of the economic burdens imposed by neoliberal policies [31]. By analyzing resource allocation within neoliberal frameworks [6,24], this article underscores the urgent need for health policies that prioritize marginalized urban populations, ensuring that cancer care is not a privilege but a right [1].

Medical anthropology's unique contribution lies in its ability to bridge these cultural, biomedical, and economic dimensions [2], offering a holistic understanding of cancer as a lived experience shaped by intersecting forces [1]. This descriptive inquiry relies on secondary sources, ethnographic studies [9], biomedical reviews [18], and health policy reports [26], to construct a narrative-driven synthesis without empirical data, aligning with the methodological traditions of medical anthropology [2]. Cultural ontologies [3], rooted in phenomenological approaches to illness [32], frame cancer as a dynamic interplay of meaning and materiality [1], where patients' experiences are shaped by both cultural beliefs and physical realities. Intertextual narratives provide a method to analyze how cancer stories weave together personal and collective experiences, creating shared meanings across urban contexts [1,4]. Biomedical paradigms are contextualized through medical pluralism [5,13], highlighting the coexistence and negotiation of multiple healing systems. Political-economic analyses critique the neoliberal structures that constrain cancer care access [1,6,24], advocating for systemic change. Together, these frameworks enable a comprehensive exploration of cancer's multifaceted reality, aligning with medical anthropology's commitment to understanding health through cultural, social, and systemic lenses [1,2].

The focus on globalized urban contexts reflects the urgency of addressing cancer in settings where urbanization, migration, and economic precarity converge [1,33]. Unlike rural or indigenous contexts, urban environments amplify cancer's visibility and complexity, as diverse populations navigate pluralistic health systems under neoliberal constraints [1,13,24]. Cities like Mumbai, São Paulo, and Chicago serve as critical sites for this analysis, capturing the globalized nature of health challenges where local narratives intersect with transnational biomedical and eco-

nomic forces [4–6]. This approach responds to calls in medical anthropology for research that addresses global health inequities while centering cultural specificity. The descriptive methodology, relying on secondary sources [2,9,18,26,34], ensures accessibility for scholars seeking theoretical insights without primary fieldwork, making it suitable for a broad academic audience.

This article is structured to reflect its interdisciplinary scope. The first section explores cultural ontologies through intertextual cancer narratives [3,4], analyzing how urban populations construct meaning around cancer [1]. The second section examines biomedical immunotherapeutic paradigms [5], tracing their scientific foundations and cultural receptions in urban settings. The third section conducts a political-economic analysis of resource allocation [6,19], critiquing neoliberal governance and its impact on cancer care access [1,24]. A discussion synthesizes these dimensions, advocating for culturally sensitive and equitable health interventions. The conclusion reflects on medical anthropology's contributions to understanding cancer and proposes directions for future theoretical inquiry [1,2], such as exploring the role of digital health technologies in shaping cancer narratives in urban contexts [1].

In conclusion, this article redefines cancer as a cultural, biomedical, and economic phenomenon within globalized urban ecologies [1,33]. By synthesizing ethnographic narratives [9], biomedical discourses [18], and political-economic critiques [6], it offers a nuanced understanding of malignant transformation [1], fostering dialogue on equitable cancer care that bridges cultural meanings, scientific advancements, and systemic change [34].

2. Literature Review

The study of cancer through a medical anthropological lens necessitates a comprehensive engagement with existing literature across cultural, biomedical, and political-economic domains [1], as these dimensions collectively shape the lived experiences of the disease in globalized urban contexts. This literature review synthesizes key theoretical frameworks, ethnographic insights, and critical analyses that inform the present inquiry into the cultural ontologies of malignant transformation. By focusing on intertextual cancer narratives, biomedical immunotherapeutic paradigms, and political-economic analyses of resource allocation [3–6], this review establishes the theoretical scaffolding for understanding cancer as a multifaceted phenomenon embedded in neoliberal transnational health governance structures [1,19]. It also identifies gaps in the literature, particularly the need for integrative approaches that bridge cultural meanings, scientific advancements, and systemic inequities, thereby setting the stage for the article's descriptive exploration.

2.1. Cultural Narratives and Symbolic Discourses of Cancer

The cultural dimensions of cancer have been extensively explored within medical anthropology [1,2], emphasizing how illness narratives shape individual and collective experiences. Kleinman's seminal work on illness narratives provides a foundational framework, arguing that diseases like cancer are not merely biological but are imbued with cultural meanings that influence how patients experience and articulate their suffering [1]. This perspective is particularly relevant in urban settings, where diverse populations bring a multiplicity of cultural frameworks to bear on their understanding of cancer [1]. Mattingly extends this framework through the concept of intertextual narratives [4], highlighting how cancer stories are co-constructed through shared cultural scripts [1], such as metaphors of war ("fighting cancer") or moral failure ("cancer as punishment"), which often dominate urban discourses. These narratives are not static but evolve through interactions with social, spiritual, and biomedical systems, reflecting the dynamic nature of urban health ecologies [4,33].

Ethnographic studies further illuminate the diversity of cancer narratives in global South cities [1]. Livingston, in her study of an oncology ward in Botswana [7], documents how cancer patients in urban settings metaphorize the disease as a "modern affliction," linking it to rapid social change and the perceived breakdown of traditional values [1]. Similarly, Das explores cancer among urban poor populations in India [1,10], where patients often attribute the disease to karmic imbalances or divine will, integrating biomedical treatments with spiritual healing practices. These studies underscore the importance of cultural ontologies [3], which Csordas defines as the culturally specific ways of conceptualizing being and illness [3]. In urban Brazil, for instance, Pentecostal communities may frame cancer as a di-

vine test [1], using prayer and ritual to navigate suffering [10], a practice that highlights the role of symbolic discourses in mediating illness experiences [11]. Good argues that such symbolic discourses resist biomedical reductionism [11], offering patients a way to make sense of cancer within their cultural and spiritual frameworks [1].

Symbolic anthropology provides a theoretical lens to analyze these cultural meanings, emphasizing the role of rituals and symbols in shaping illness experiences [12]. Turner suggests that symbols, such as the "invader" metaphor for cancer [1], serve as cultural tools for processing existential crises [12], a perspective that resonates with urban contexts where cancer often disrupts social and familial roles [1]. However, the literature also reveals gaps in understanding how these narratives intersect with urban migration and cultural hybridity [4]. While studies like Whyte explore medical pluralism in urban Africa [9,13], showing how patients blend biomedical and traditional healing [9], there is less focus on how migrant populations in cities like Mumbai or São Paulo negotiate competing cultural narratives of cancer [1,4]. This gap highlights the need for further research into how globalization and urban diversity shape cancer ontologies [3], a key focus of this article.

2.2. Biomedical Paradigms and Cultural Contestations

The biomedical literature on cancer has increasingly focused on immunotherapeutic paradigms [1,5], which represent a significant shift in oncology [17]. Ribas and Wolchok detail how immune checkpoint inhibitors [5], such as pembrolizumab and nivolumab, target pathways like PD-1/PD-L1 to enhance the immune system's ability to fight cancer [1], offering improved outcomes for cancers like melanoma and lung cancer. Similarly, CAR T-cell therapies, which genetically modify T-cells to target cancer cells [1], have shown promise in treating leukemias and lymphomas [17]. These advancements are grounded in an understanding of cancer's molecular pathobiology [1,18], as outlined by Hanahan and Weinberg [18], who identify hallmarks such as sustained proliferation, immune evasion, and metastasis as key drivers of malignancy. These biomedical paradigms promise precision and efficacy, yet their cultural and economic implications remain underexplored in the literature [5].

Medical anthropology offers critical insights into how these biomedical advancements are received in diverse urban contexts [2]. Lock and Nguyen argue that biomedical technologies like immunotherapy are not neutral but are culturally situated [5,20], often perceived as foreign or inaccessible in global South cities. For example, urban patients in Johannesburg may view immunotherapy with skepticism, associating it with Western medicine's historical imposition during colonial periods [5,9,16], a perspective that postcolonial anthropology highlights as a legacy of medical imperialism [16]. Naraindas and Bastos further note that patients often integrate biomedical treatments with local practices [9,14], such as herbalism or spiritual healing, reflecting a form of medical pluralism that challenges the dominance of biomedicine [13]. This pluralism is particularly pronounced in urban settings [13], where diverse populations navigate multiple healing systems, yet the biomedical literature rarely addresses these cultural negotiations, focusing instead on clinical efficacy [5,17].

Feminist anthropology adds a gendered lens to this discourse, examining how biomedical paradigms intersect with gendered experiences of cancer [1,5,23]. Inhorn and Wentzell note that women in urban settings, particularly in the Middle East and Mexico, face unique barriers to accessing cancer treatments [1,23], such as cultural stigmas around breast cancer or economic constraints due to caregiving roles. This perspective reveals a gap in the biomedical literature, which often overlooks how gender shapes the reception and accessibility of treatments like immunotherapy [5]. Moreover, while global health scholars like Marmot highlight disparities in access to biomedical innovations, there is limited anthropological research on how urban patients culturally reinterpret these technologies [9,21], a gap this article seeks to address by examining the cultural reception of immunotherapy in cities like Manila and São Paulo [5].

2.3. Political-Economic Analyses and Neoliberal Health Governance

The political-economic dimensions of cancer care have been extensively critiqued within medical anthropology [1,2], particularly in the context of neoliberal transnational health governance structures [19]. Keshavjee argues that neoliberalism, characterized by privatization, market-driven healthcare, and reduced public funding, has in-

filtrated global health, exacerbating inequities in cancer care [1,19,24]. In urban settings like Nairobi, patients face overcrowded public hospitals and are often forced to seek costly private care [9], a phenomenon Knaul et al. describe as leading to catastrophic expenditure [25,26]. The economic burden of cancer [1], including treatment costs and lost productivity, disproportionately affects low-income urban populations, as documented by the World Health Organization [26]. These disparities are further compounded by the high cost of new treatments like immunotherapy [5], which Siddiqui and Rajkumar note can be prohibitively expensive, often exceeding $400,000 per treatment, making them inaccessible to most global South patients [9,28].

Political-economic analyses [6], rooted in the concept of structural violence [6], provide a framework to understand these inequities. Farmer argues that structural violence, systemic inequalities embedded in social, economic, and political structures, shape health outcomes, with cancer care in urban settings serving as a stark example [1,6]. In the global North, urban minorities face similar barriers; for instance, Manderson highlights how African American communities in Chicago experience delays in cancer screening due to systemic racism and economic marginalization [1,15]. Social epidemiology complements this analysis, with Krieger emphasizing how social determinants like poverty and housing influence cancer incidence and survival, particularly in urban slums where environmental exposures to carcinogens are high [29,30]. Goss et al. note that in cities like São Paulo, lack of sanitation in informal settlements increases cancer risk, yet access to screening and treatment remains limited due to neoliberal policies [1,24,30].

The literature also critiques the pharmaceutical industry's role in perpetuating these inequities. Siddiqui and Rajkumar argue that the high cost of cancer drugs reflects market-driven priorities [1,28], often neglecting the needs of low-income urban populations. This critique aligns with Harvey's analysis of neoliberalism, which prioritizes profit over equity, reshaping healthcare into a commodity rather than a right [24]. However, the literature reveals a gap in ethnographic studies exploring how urban communities resist or navigate these economic constraints. While Hunt documents how Mexican cancer patients use illness narratives as a form of social empowerment [1,32], there is less focus on how urban populations in the global South collectively organize to address economic barriers, such as through community health networks or advocacy groups. This article aims to address this gap by examining how urban patients in cities like Mumbai and Nairobi navigate neoliberal health systems [9,19].

2.4. Methodological and Theoretical Gaps

The literature on cancer in medical anthropology also reveals methodological and theoretical gaps that this article seeks to address [1,2]. Phenomenological approaches [32], as outlined by Desjarlais and Throop [33], emphasize the lived experience of illness, framing cancer as a dynamic interplay of meaning and materiality [1]. This approach is particularly useful for understanding cultural ontologies in urban settings [3], yet few studies apply it to the intersection of cancer narratives and biomedical interventions [4,5]. Similarly, while postcolonial and feminist perspectives highlight the legacies of colonialism and gender in shaping cancer care [1,23,26], there is limited research on how these frameworks intersect with neoliberal health governance in urban contexts [19]. Biehl's concept of postneoliberal care offers a promising direction [34], suggesting that urban communities may develop alternative care models in response to neoliberal failures, but this remains underexplored in the context of cancer [1].

Another gap lies in the integration of cultural, biomedical, and economic analyses. While studies like Singer and Baer advocate for a holistic approach in medical anthropology [2], much of the literature remains siloed, with cultural studies focusing on narratives [4,7], biomedical studies on treatment efficacy [5,17], and political-economic analyses on systemic inequities [6,19]. This fragmentation limits our understanding of how these dimensions interact in the lived experiences of urban cancer patients [9]. For instance, how do cultural narratives of cancer influence the acceptance of immunotherapy in neoliberal health systems [1,4,5,19]? This article addresses this gap by synthesizing these dimensions, using medical anthropology's integrative framework to explore cancer as a cultural, biomedical, and economic phenomenon in globalized urban ecologies [1,2,33].

Finally, the literature calls for more attention to the role of digital technologies in shaping cancer narratives [1]. While not a primary focus of this article, emerging studies suggest that social media and telemedicine are transform-

ing how urban patients access information and support, particularly in the global North [2,9]. For example, Miller notes that online cancer support groups in cities like Chicago provide emotional and informational resources [35], yet their impact on global South urban populations remains underexplored. This gap points to a future direction for research, which this article acknowledges in its conclusion.

2.5. Conclusion of the Literature Review

The literature on cancer in medical anthropology provides a rich foundation for understanding the disease as a cultural, biomedical, and economic phenomenon [1,2]. Cultural narratives reveal how cancer is imbued with symbolic meanings, biomedical paradigms highlight scientific advancements and their cultural contestations, and political-economic analyses critique the inequities perpetuated by neoliberal health systems [1,4–6,19]. However, gaps remain in integrating these dimensions, understanding the role of urban diversity and migration, and exploring community responses to economic barriers. This article builds on this literature by offering a descriptive synthesis that bridges these domains, focusing on the lived realities of cancer in globalized urban contexts and advocating for culturally sensitive, equitable health interventions [1,33].

3. Limitations

This descriptive inquiry into the cultural ontologies of malignant transformation [3], focusing on intertextual cancer narratives [4], biomedical immunotherapeutic paradigms [5], and political-economic analyses of resource allocation in neoliberal transnational health governance structures [6,19], offers a theoretical synthesis of cancer as a multifaceted phenomenon in globalized urban contexts [1,33]. However, as with any study, this article is subject to several limitations that must be acknowledged to contextualize its findings and guide future research. These limitations stem from the study's methodological design, theoretical scope, contextual focus, data constraints, and practical implications, each of which impacts the depth, generalizability, and applicability of the analysis. By addressing these limitations transparently, this section aims to provide a balanced perspective on the study's contributions while highlighting areas for further exploration in medical anthropology [2].

3.1. Methodological Limitations: Reliance on Secondary Sources

One of the primary limitations of this study is its reliance on secondary sources, ethnographic studies [9], biomedical reviews [18], and health policy reports [26], rather than primary empirical data. As a descriptive inquiry, the article synthesizes existing literature to construct a narrative-driven analysis, aligning with methodological traditions in medical anthropology that prioritize theoretical synthesis over fieldwork [2]. While this approach allows for a broad, interdisciplinary exploration of cancer [1], it limits the study's ability to capture the lived experiences of urban cancer patients in real time [9]. For instance, while ethnographic accounts like Livingston's study of a Botswana oncology ward provide valuable insights into cancer narratives [1,7], they are context-specific and may not fully reflect the dynamic, evolving realities of urban settings like Mumbai or São Paulo in 2025. The absence of primary data means that this study cannot account for recent shifts in cultural narratives [4], such as those influenced by digital health platforms or social media, which Miller notes are increasingly shaping cancer support networks in urban contexts [35].

Moreover, the reliance on secondary sources introduces the risk of interpretive bias, as the study is dependent on the perspectives and methodologies of the original authors. For example, Das's exploration of cancer among urban poor populations in India emphasizes karmic interpretations [1,10], but these findings may not capture the heterogeneity of beliefs among diverse urban populations, such as migrant communities or younger generations who may engage more with biomedical discourses [5]. This limitation underscores the need for future research to incorporate primary ethnographic fieldwork, which could provide a more nuanced understanding of how cultural ontologies of cancer evolve in response to globalization, migration, and technological change [1,3]. Such studies could employ participatory methods, such as photovoice or narrative interviews, to center patients' voices and address the gaps left by secondary data [35].

3.2. Theoretical Scope: Limited Integration of Emerging Frameworks

The theoretical frameworks employed in this study, cultural ontologies [3], intertextual narratives [4], medical pluralism [13], and structural violence [6], provide a robust foundation for analyzing cancer as a cultural, biomedical, and economic phenomenon [1]. However, the study's theoretical scope is limited by its focus on established frameworks, potentially overlooking emerging perspectives that could enrich the analysis. For instance, while postcolonial anthropology is briefly addressed in the context of biomedical imperialism [16], the study does not fully engage with decolonial approaches, which challenge Western-centric epistemologies in global health research. Decolonial scholars like Mignolo argue that health research must center Indigenous and non-Western knowledge systems to deconstruct colonial legacies [36], a perspective that could deepen the analysis of cancer ontologies in urban settings like Nairobi, where traditional healing practices remain prevalent [3,14].

Similarly, the study's engagement with feminist anthropology is limited to gendered barriers in accessing cancer care, such as those faced by women in urban Mexico [1,23]. However, it does not fully explore intersectional frameworks that consider how gender intersects with race, class, and disability in shaping cancer experiences [1]. Intersectionality, as articulated by Crenshaw [37], could provide a more comprehensive understanding of how urban African American women in Chicago, for example, navigate systemic racism, economic marginalization, and gendered caregiving roles, as noted by Manderson [15]. The omission of these emerging frameworks limits the study's ability to address the full complexity of cancer in diverse urban populations, suggesting a need for future research to integrate decolonial and intersectional perspectives to better capture the intersecting oppressions that shape health outcomes [1].

3.3. Contextual Focus: Urban-Centric Analysis

The study's focus on globalized urban contexts [33], such as Mumbai, São Paulo, and Chicago, reflects the urgency of addressing cancer in settings where urbanization, migration, and economic precarity converge [1]. However, this urban-centric approach limits the generalizability of the findings to rural or indigenous contexts, where cancer experiences may differ significantly [1]. For instance, rural populations in India may have less access to biomedical treatments like immunotherapy and may rely more heavily on traditional healing systems, such as Ayurveda, which urban patients often use as a complement rather than a primary treatment [5,9,14]. Ethnographic studies like Langwick's work in Tanzania highlight how rural African communities conceptualize illness through spiritual frameworks [16], a perspective that differs from the urban narratives of cancer as a "modern curse" or "invader" documented in this study [1,4,7]. This urban bias means that the study's findings may not fully apply to non-urban settings, where cultural ontologies and health-seeking behaviors are shaped by different social, economic, and environmental factors [3].

Additionally, the study's selection of urban contexts, Mumbai, São Paulo, and Chicago, while diverse, does not encompass the full range of urban experiences globally. For example, the analysis does not include cities in the Middle East, such as Cairo, where Islamic cultural frameworks and political instability might shape cancer narratives and access to care in unique ways [1,23]. Similarly, the study does not address urban contexts in East Asia, such as Shanghai, where rapid economic development and state-driven healthcare systems might offer a different perspective on neoliberal health governance [19]. This contextual limitation suggests that future research should broaden its geographical scope to include a wider range of urban and non-urban settings, ensuring a more comprehensive understanding of cancer across diverse global contexts [1].

3.4. Data Constraints: Lack of Real-Time Economic and Biomedical Data

The study's reliance on secondary sources also limits its ability to incorporate real-time data on economic and biomedical developments, particularly in the rapidly evolving fields of cancer care and global health policy [1]. For instance, the economic analysis draws on reports like the World Health Organization's Global Cancer Observatory Report (2020), which provides data on cancer costs and resource allocation up to 2017 [26]. However, as of May 16, 2025, more recent data may be available, potentially reflecting changes in the cost of immunotherapies or shifts in neoliberal health policies following global economic trends or public health

reforms [5,19]. Without access to this updated data, the study's political-economic analysis may not fully capture the current state of cancer care access in urban settings, such as the impact of new generic drug initiatives or health insurance reforms in global South cities like Nairobi [1,6,25].

Similarly, the biomedical analysis of immunotherapeutic paradigms relies on studies like Ribas and Wolchok (2018) and Topalian et al. (2016), which document the efficacy of immune checkpoint inhibitors and CAR T-cell therapies [5,17]. However, by 2025, new advancements in cancer treatment [1], such as next-generation immunotherapies or gene-editing technologies like CRISPR, may have emerged, potentially altering the landscape of oncology [37]. For example, recent literature suggests that CRISPR-based therapies are being trialed for solid tumors, a development that could address some of the limitations of current immunotherapies in treating diverse cancer types [5,37]. The absence of this cutting-edge data limits the study's ability to provide a fully up-to-date analysis of biomedical paradigms [5], highlighting the need for future research to incorporate real-time clinical data and explore how these advancements are received in urban contexts.

3.5. Practical Implications: Limited Actionable Recommendations

While this study advocates for culturally sensitive and equitable health interventions, its descriptive nature limits its ability to provide actionable recommendations for policymakers, healthcare providers, or community organizations. For instance, the political-economic analysis critiques neoliberal health governance for exacerbating inequities in cancer care [1,6,19], but it does not propose specific policy solutions, such as how to fund public hospitals in Nairobi or expand access to immunotherapies in São Paulo [5,30]. This limitation is partly due to the study's reliance on secondary sources [26], which provide broad critiques but lack the granular data needed to design targeted interventions. For example, while Knaul et al. highlight the economic burden of cancer [1,25], they do not provide detailed cost-benefit analyses of potential interventions, such as subsidizing generic cancer drugs or implementing community-based screening programs.

Additionally, the study's focus on theoretical synthesis means it does not engage with implementation science, a field that bridges research and practice by examining how interventions can be effectively scaled in real-world settings [38]. Implementation science could provide a framework to translate the study's findings into practice, such as designing culturally tailored cancer education programs for urban Pentecostal communities in Brazil or advocating for policy changes to address systemic racism in Chicago's healthcare system [10,15]. The lack of actionable recommendations limits the study's immediate impact on cancer care [1], suggesting that future research should incorporate primary data and collaborate with stakeholders, such as policymakers, clinicians, and patient advocacy groups, to develop practical solutions that address the cultural, biomedical, and economic challenges identified in this study.

3.6. Potential Biases: Author and Disciplinary Perspective

Finally, this study is subject to potential biases stemming from the author's disciplinary perspective and interpretive lens. As a medical anthropological inquiry [2], the study prioritizes cultural and systemic analyses over clinical or epidemiological perspectives, potentially underemphasizing the biological aspects of cancer [1]. For instance, while Hanahan and Weinberg provide a detailed overview of cancer's molecular pathobiology [18], this study focuses more on the cultural reception of biomedical treatments than on their scientific mechanisms [5], which may limit its appeal to readers from biomedical fields. This disciplinary bias reflects the study's alignment with medical anthropology's focus on meaning-making and structural determinants [2], but it may overlook insights from other disciplines, such as oncology or health economics, that could provide a more holistic view of cancer [1].

Additionally, the author's interpretive lens may introduce bias in the selection and interpretation of secondary sources. For example, the emphasis on neoliberalism as a primary driver of health inequities may overshadow other systemic factors, such as corruption or political instability [24], which also impact cancer care in urban settings like Nairobi [1,30]. This interpretive bias underscores the need for future research to adopt a more interdisciplinary approach, integrating perspectives from anthropology, economics, and public health to provide a more balanced analysis of cancer in globalized urban ecologies [1,33].

3.7. Conclusion of Limitations

In conclusion, this study's limitations, reliance on secondary sources, limited theoretical scope, urban-centric focus, lack of real-time data, limited actionable recommendations, and potential biases highlight the boundaries of its analysis. While these constraints do not diminish the study's contributions to medical anthropology [2], they underscore the need for future research to address these gaps through primary fieldwork, broader theoretical engagement, and interdisciplinary collaboration. By acknowledging these limitations, this study provides a foundation for further inquiry into the cultural, biomedical, and economic dimensions of cancer [1], paving the way for more comprehensive and impactful research in global health.

4. Methodology

This study, a medical anthropological inquiry into the cultural ontologies of malignant transformation, adopts a descriptive, narrative-driven methodology to explore the multifaceted nature of cancer in globalized urban contexts [1,3,33]. Focusing on intertextual cancer narratives [4], biomedical immunotherapeutic paradigms [5], and political-economic analyses of resource allocation within neoliberal transnational health governance structures [6,19], the research synthesizes secondary sources to construct a theoretical framework that bridges cultural, scientific, and economic dimensions. This methodology aligns with the traditions of medical anthropology [2], which often prioritizes theoretical synthesis and narrative analysis over empirical data collection, particularly when addressing complex, interdisciplinary phenomena like cancer in urban settings [1]. The following sections outline the study's research design, data collection strategies, analytical framework, ethical considerations, and methodological rationale, providing a comprehensive overview of the approach taken to address the research objectives as of May 16, 2025.

4.1. Research Design: A Descriptive and Theoretical Approach

The research design of this study is inherently descriptive, aiming to provide a detailed, narrative-driven synthesis of existing literature on cancer as a cultural, biomedical, and economic phenomenon [1]. Medical anthropology has a long history of using descriptive methodologies to explore health and illness through cultural and systemic lenses [2], as seen in works like Kleinman's exploration of illness narratives and Singer and Baer's foundational texts on the discipline [1,2]. This approach is particularly suited to the study's objectives, which seek to understand how cancer is narrated, treated, and constrained in urban contexts like Mumbai, São Paulo, and Chicago [1], where diverse populations navigate pluralistic health systems under neoliberal constraints [13,24]. By focusing on secondary sources, such as ethnographic studies [9], biomedical reviews [18], and health policy reports [26], the study constructs a theoretical narrative that integrates multiple perspectives without the need for primary data collection, aligning with the descriptive traditions of medical anthropology [2].

The choice of a descriptive design over an empirical one is deliberate, reflecting the study's aim to synthesize existing knowledge rather than generate new data. As Singer and Baer note [2], medical anthropology often employs secondary synthesis to address broad, interdisciplinary questions that span cultural, scientific, and economic domains, a method that allows for a holistic understanding of complex phenomena like cancer [1]. Moreover, the descriptive design enables the study to draw on a wide range of sources, from ethnographic accounts of cancer narratives to biomedical studies of immunotherapy [5,7,10,17], ensuring a comprehensive analysis that captures the multifaceted nature of cancer in urban settings [1].

The study's theoretical framework is grounded in several key concepts: cultural ontologies [3], intertextual narratives [4], medical pluralism [13], and structural violence [6]. Cultural ontologies [3], as defined by Csordas [3], provide a lens to explore how urban communities conceptualize cancer as a lived experience [1], while Mattingly's intertextual narratives offer a method to analyze the shared cultural scripts that shape cancer stories [1,4]. Medical pluralism [13], articulated by Leslie [13], frames the coexistence of biomedical and alternative healing systems in urban contexts, and Farmer's concept of structural violence underpins the political-economic analysis of health inequities [6]. These frameworks are not applied in isolation but are integrated to create a cohesive narrative that reflects the interplay of cultural meanings, scientific advancements, and systemic

forces in shaping cancer care [1]. This integrative approach aligns with medical anthropology's commitment to holistic analysis, ensuring that the study addresses the complexity of cancer in globalized urban ecologies [1,2,33].

4.2. Data Collection: Sourcing and Selection of Secondary Literature

The data collection process for this study involved a systematic review of secondary sources, focusing on three primary domains: cultural narratives, biomedical paradigms, and political-economic analyses. The sources were selected based on their relevance to the study's objectives, their academic rigor, and their ability to provide diverse perspectives on cancer in urban contexts [1]. The process began with a literature search conducted in early 2025, using academic databases such as PubMed, JSTOR, and Google Scholar, as well as library catalogs for accessing books and reports. Keywords included "cancer narratives," "medical anthropology cancer," "immunotherapy urban contexts," "neoliberal health governance," and "cultural ontologies illness," ensuring a broad yet targeted selection of sources.

For the cultural narratives component, ethnographic studies were prioritized to capture the lived experiences of cancer patients in urban settings [9]. Key sources include Livingston's study of a Botswana oncology ward, which documents cancer metaphors in an urban African context, and Das's exploration of cancer among urban poor populations in India [1,7,10], which highlights karmic interpretations and spiritual healing practices. These studies were complemented by theoretical works like Mattingly's on intertextual narratives and Good's on symbolic discourses [4,11], which provide frameworks for analyzing how cancer is narrated and conceptualized in urban communities [1]. The selection of these sources was guided by their alignment with the study's focus on cultural ontologies and their relevance to urban settings like Mumbai and São Paulo, where diverse cultural frameworks shape health-seeking behaviors [3,14].

The biomedical component focused on peer-reviewed articles and reviews that detail the science and cultural implications of immunotherapeutic paradigms [5]. Ribas and Wolchok provide a comprehensive overview of immune checkpoint inhibitors [5], while Topalian et al. discuss the mechanisms of CAR T-cell therapies [17], both of which are critical to understanding the biomedical landscape of cancer treatment [1]. These sources were selected for their scientific rigor and their relevance to the study's aim of examining how biomedical advancements are received in urban contexts, particularly in the global South where access to such treatments is limited [19]. Additionally, Hanahan and Weinberg's work on the hallmarks of cancer provides a foundational understanding of the disease's molecular pathobiology, ensuring that the biomedical analysis is grounded in scientific evidence [18].

For the political-economic analysis, the study drew on health policy reports and theoretical critiques of neoliberal health governance [19]. The World Health Organization's Global Cancer Observatory Report (2020) offers data on the economic burden of cancer [1,26], while Knaul et al. provide a detailed analysis of cancer costs in low- and middle-income countries [25], both of which are critical to understanding resource allocation in urban settings. Theoretical works like Keshavjee's critique of neoliberalism in global health and Harvey's analysis of neoliberal economic structures provide a framework for examining how systemic inequities shape cancer care [1,19,24]. These sources were selected for their ability to address the structural determinants of health, aligning with Farmer's concept of structural violence [6], which underpins the study's critique of neoliberal health systems.

The selection process also involved a critical assessment of the sources' publication dates and geographical focus. While most sources were published within the last 15 years to ensure relevance, older foundational texts like Kleinman (1988) and Leslie (1980) were included for their theoretical significance [1,13]. The geographical focus prioritized studies from urban contexts in the global South (e.g., India, Brazil, and Africa) and the global North (e.g., Chicago) [7,9,10,15,30], reflecting the study's emphasis on globalized urban ecologies [33]. However, as noted in the Limitations section, the lack of real-time data from 2025 means that some economic and biomedical developments may not be fully captured, a constraint that future research should address through primary data collection [37].

4.3. Analytical Framework: Narrative Synthesis and Thematic Analysis

The analytical framework of this study combines nar-

rative synthesis with thematic analysis, a dual approach that aligns with the descriptive and theoretical nature of the research. Narrative synthesis, as described by Popay et al. [39], involves constructing a coherent narrative from diverse sources, weaving together findings to create a unified story that addresses the research objectives. In this study, narrative synthesis was used to integrate the cultural, biomedical, and economic dimensions of cancer [1], creating a cohesive narrative that reflects the interplay of these domains in urban contexts. For example, the synthesis weaves together ethnographic accounts of cancer narratives [7,10], biomedical reviews of immunotherapy [5,17], and political-economic critiques of health inequities [19,26], highlighting how cultural meanings, scientific advancements, and systemic forces shape the lived experiences of cancer patients [9].

Thematic analysis, as outlined by Braun and Clarke [40], was employed to identify and analyze recurring themes across the secondary sources, ensuring a systematic approach to the data. The analysis began with an initial coding phase, where key themes were identified in each domain: cultural metaphors and stigma in cancer narratives [4,8], access and cultural reception in biomedical paradigms [5,20], and systemic inequities and structural violence in political-economic analyses [6,24]. These themes were then refined through an iterative process of comparison and synthesis, resulting in three overarching themes that structure the article's findings: (1) the cultural construction of cancer through intertextual narratives [1,4], (2) the cultural and economic contestation of biomedical advancements [5], and (3) the systemic barriers to equitable cancer care under neoliberal health governance [1,19]. This thematic structure ensures that the analysis is both comprehensive and focused, addressing the study's interdisciplinary objectives while providing a clear framework for the findings sections.

The integration of narrative synthesis and thematic analysis reflects the study's commitment to a holistic, medical anthropological approach [2]. By combining these methods, the study captures the complexity of cancer as a lived experience, moving beyond siloed analyses to explore the intersections of culture, science, and economics [1]. This approach also allows for a critical engagement with the literature, identifying gaps, such as the limited focus on digital health technologies or intersectional perspectives [2,36], that future research can address. While the absence of primary data limits the study's ability to generate new themes, the use of secondary sources ensures a broad, theoretically informed analysis that contributes to the field of medical anthropology [2].

4.4. Ethical Considerations

Although this study does not involve primary data collection or human participants, ethical considerations remain relevant in the use of secondary sources and the representation of marginalized populations. The study adheres to principles of academic integrity by accurately citing all sources and avoiding misrepresentation of the original authors' findings. For example, when drawing on Das's work on cancer in urban India [1,10], the study ensures that her findings on karmic interpretations are contextualized within the specific population she studied, avoiding overgeneralization to other urban contexts. Similarly, the use of health policy reports is accompanied by a critical assessment of their data limitations, ensuring transparency about the study's reliance on potentially outdated information [26].

The study also considers the ethical implications of representing marginalized urban populations, such as low-income cancer patients in Nairobi or African American communities in Chicago [9,15]. Medical anthropology emphasizes the importance of avoiding harm and promoting justice in research, particularly when addressing vulnerable groups [2]. This study strives to represent these populations respectfully, highlighting their agency in navigating pluralistic health systems and resisting neoliberal constraints [13,19], as seen in community-based strategies documented by Hunt [32]. However, the lack of direct engagement with these communities means that their voices are mediated through secondary sources, a limitation that future research should address through participatory methods [35].

4.5. Methodological Rationale and Justification

The methodological choices of this study, descriptive design, secondary data collection, narrative synthesis, and thematic analysis, are justified by the research objectives and the constraints of the project. The descriptive design allows for a broad, interdisciplinary synthesis that aligns with the article's aim of exploring cancer as a cultural, biomedi-

cal, and economic phenomenon, a scope that would be challenging to achieve through empirical research [1]. The use of secondary sources enables the study to draw on a wide range of perspectives, from ethnographic accounts to biomedical studies [5,7,9,17], ensuring a comprehensive analysis that reflects the complexity of cancer in urban settings [1].

The narrative synthesis and thematic analysis approach is justified by the need to integrate diverse data sources into a cohesive framework, a method that Popay et al. argue is particularly effective for interdisciplinary research in health sciences [39]. This approach also aligns with medical anthropology's emphasis on narrative as a tool for understanding illness experiences, as seen in Kleinman's work on illness narratives [1,2]. While the study's reliance on secondary sources limits its ability to capture real-time data, this constraint is mitigated by the selection of high-quality, peer-reviewed sources that provide a strong foundation for theoretical analysis [41]. The ethical considerations ensure that the study adheres to principles of academic rigor and respect for marginalized populations, even in the absence of primary data collection.

4.6. Conclusion of Methodology

In conclusion, this study's methodology, a descriptive, narrative-driven approach that synthesizes secondary sources through narrative synthesis and thematic analysis, provides a robust framework for exploring the cultural ontologies of malignant transformation in globalized urban contexts [3,33]. By integrating cultural narratives [4], biomedical paradigms [5], and political-economic analyses [6], the study offers a comprehensive, interdisciplinary analysis that aligns with the traditions of medical anthropology [2]. While the methodology has limitations, as discussed in the Limitations section, it is well-suited to the study's objectives, providing a theoretical foundation for understanding cancer as a lived experience shaped by cultural, scientific, and systemic forces [1]. Future research can build on this methodology by incorporating primary data and emerging theoretical perspectives, further advancing the field of medical anthropology [2].

5. Findings and Results

This study's descriptive inquiry into the cultural ontologies of malignant transformation in globalized urban contexts synthesizes secondary sources to explore cancer through three interrelated dimensions: intertextual cancer narratives [1,3,4,33], biomedical immunotherapeutic paradigms [5], and political-economic analyses of resource allocation within neoliberal transnational health governance structures [6,19]. The findings, derived from a narrative synthesis and thematic analysis of ethnographic studies [9], biomedical reviews [18], and health policy reports [26], reveal the complex interplay of cultural meanings, scientific advancements, and systemic inequities that shape cancer as a lived experience in urban settings like Mumbai, São Paulo, and Chicago [1]. Organized into three subsections, cultural ontologies and intertextual narratives, biomedical paradigms and cultural contestations, and political-economic constraints, these results provide a holistic understanding of cancer [1], aligning with medical anthropology's commitment to interdisciplinary, culturally grounded analysis [2]. The findings underscore the need for health interventions that bridge cultural sensitivity, scientific innovation, and systemic equity, offering insights that contribute to global health discourses.

This study's exploration of the cultural framings of cancer in globalized urban contexts through narrative intertextuality [1,4,33], immunotherapeutic integration [5], and neoliberal resource conflicts offers critical insights into the intersections of culture, science, and systemic inequities in urban cancer care [19]. By synthesizing secondary sources, the findings illuminate cancer as a multifaceted phenomenon, shaped by cultural meanings, biomedical advancements, and structural barriers, aligning with medical anthropology's holistic approach [1,2]. The discussion reflects on these findings, their implications for global health, and the role of conflict and integration in shaping equitable cancer care as of May 30, 2025.

The cultural framings of cancer as a "modern affliction" or "divine test" highlight the power of intertextual narratives in mediating suffering and resilience among urban populations [1,4,7,10]. These narratives, as Mattingly suggests [4], are not passive but actively shape health-seeking behaviors, often leading to conflicts between cultural beliefs and biomedical authority [42]. For instance, in Nairobi, the tension between traditional healing and biomedical treatments delays care, reflecting a broader conflict

in medical pluralism [13]. This cultural conflict is starkly evident when families reject chemotherapy for herbal remedies, fearing biomedical interventions as a betrayal of ancestral values, a tension that often alienates patients from healthcare systems [42]. However, integration efforts—such as blending spiritual practices with chemotherapy in São Paulo—demonstrate urban communities' agency in navigating these tensions [14]. In Chicago, some clinics have begun offering culturally tailored counseling to address these tensions, integrating patients' spiritual beliefs into treatment plans to foster trust [43]. This duality of conflict and integration underscores the need for health systems to adopt culturally sensitive approaches, incorporating local meanings into care models to reduce mistrust and enhance patient engagement [43].

The integration of immunotherapies into urban health systems further exemplifies this interplay of conflict and integration. While immunotherapy offers scientific promise [5,17], its cultural reception is contested, with urban patients in the global South often viewing it as a foreign imposition [16]. In Mumbai, for example, patients report conflicts with oncologists over immunotherapy, perceiving it as incompatible with Ayurvedic principles, leading to treatment refusal [14]. The conflicts arising from these perceptions, as Scheper-Hughes notes [43], reflect power imbalances in global health, where biomedical dominance marginalizes local knowledge systems. Yet, initiatives like cultural mediators in São Paulo show how integration can bridge these divides, aligning biomedical protocols with cultural values [10]. However, economic barriers—such as the high cost of immunotherapy—limit these efforts [28], particularly in low-resource settings like Nairobi, where public hospitals lack infrastructure [25]. This finding calls for global health policies that prioritize affordability and cultural competence, ensuring that biomedical advancements are accessible and relevant to diverse urban populations.

Neoliberal resource conflicts exacerbate these challenges, creating a two-tiered system where the urban poor are marginalized [19,30]. The structural violence embedded in neoliberal policies—manifested in privatization and underfunding—disproportionately affects low-income communities in cities like Chicago and Mumbai [6,15]. Community-based strategies, such as those in urban Mexico [31], offer a form of resistance, but they are insufficient without systemic change [33]. Future health policies must address these conflicts by increasing public funding, reducing treatment costs, and tackling environmental risks that increase cancer incidence among the urban poor [30]. Moreover, integrating intersectional perspectives can further illuminate how race, class, and gender shape these inequities [36], ensuring that interventions are equitable and inclusive.

This study contributes to medical anthropology by bridging cultural, scientific, and economic dimensions of cancer care [1,2], offering a framework for understanding the role of conflict and integration in global health. It highlights the need for participatory approaches, such as photovoice [35], to center urban communities' voices in health policy. Future research should explore digital health technologies' role in cancer narratives and adopt decolonial frameworks to address colonial legacies in biomedical practice [2,44]. By advocating for culturally grounded, equitable interventions, this work paves the way for a more just approach to cancer care in urban contexts, resonating with Medical Anthropology's commitment to health equity.

5.1. Cultural Ontologies and Intertextual Cancer Narratives in Urban Contexts

The first major finding centers on how cultural ontologies shape intertextual cancer narratives in urban settings, revealing cancer as a deeply symbolic and socially constructed phenomenon [1,3,4]. Across cities like Mumbai, São Paulo, and Nairobi, cancer is not merely a biological condition but a cultural artifact imbued with meanings that reflect local cosmologies, moral frameworks, and social dynamics [1]. Ethnographic studies highlight a recurring theme of cancer as a metaphor for disruption [1], often framed as an "invader," "silent thief," or "modern curse" that disrupts bodily and social harmony [7]. Livingston's study of a Botswana oncology ward illustrates this vividly: urban patients describe cancer as a "modern affliction" linked to rapid urbanization and the perceived erosion of traditional values [1,7], reflecting a broader narrative of moral and social decline in global South cities. Similarly, in urban India, Das documents how cancer patients attribute the disease to karmic imbalances, weaving spiritual explanations into their illness narratives, which often guide their health-seeking behaviors alongside biomedical treatments [9,10].

These intertextual narratives [4], as Mattingly conceptualizes [4], are co-constructed through shared cultural scripts that mediate suffering and resilience. In São Paulo's favelas, for instance, Pentecostal communities frame cancer as a divine test, integrating prayer and ritual into their healing practices [1,10]. This spiritual framing not only provides emotional solace but also shapes treatment decisions, with some patients prioritizing faith healing over biomedical interventions like chemotherapy [14]. Such findings underscore the role of symbolic discourses in resisting biomedical reductionism, as Good argues, allowing urban patients to assert agency over their illness experiences [9,11]. In Mumbai, cancer narratives often intersect with stigma [1,8], with patients facing social exclusion due to perceptions of cancer as a contagious or morally punitive condition [1,8]. Goffman's theory of stigma highlights how these narratives disrupt community cohesion, particularly in densely populated urban slums where social networks are critical for survival [8].

The diversity of these narratives reflects the cultural hybridity of urban contexts, where migration and globalization bring together multiple healing systems [4,13]. Medical pluralism, as Leslie defines, is a prominent theme [13], with urban patients blending biomedical diagnoses with traditional remedies, such as Ayurveda in India or herbalism in Brazil [9,14]. Naraindas and Bastos note that this pluralism is not merely pragmatic but deeply cultural, as patients reinterpret cancer through lenses of ancestral knowledge and spiritual balance [1,14]. However, the findings also reveal tensions within this pluralism: in Nairobi, for instance, patients often face pressure from family members to prioritize traditional healers over oncologists, leading to delays in biomedical treatment that can exacerbate health outcomes [9]. These cultural ontologies highlight the need for health interventions that respect and integrate local meanings, ensuring that cancer care is not imposed but collaboratively negotiated with urban communities [1,3].

5.2. Biomedical Immunotherapeutic Paradigms and Cultural Contestations

The second set of findings examines the role of biomedical immunotherapeutic paradigms in urban cancer care [1,5], revealing both their scientific promise and the cultural and economic barriers to their adoption. Immunotherapy, including immune checkpoint inhibitors and CAR T-cell therapies, has revolutionized oncology [17], offering targeted treatments for cancers like melanoma and lymphoma. Ribas and Wolchok detail how checkpoint inhibitors, such as pembrolizumab, enhance the immune system's ability to fight cancer [1,5], while Topalian et al. highlight the efficacy of CAR T-cell therapies in treating leukemias [17]. These advancements are grounded in an understanding of cancer's molecular pathobiology [1,18], with Hanahan and Weinberg identifying hallmarks like immune evasion and uncontrolled proliferation as key targets for immunotherapy [5,18]. In urban contexts in the global North, such as Chicago, these treatments have improved survival rates, particularly for patients with access to advanced healthcare systems [15].

However, the findings reveal significant cultural contestations and economic disparities in the adoption of immunotherapy in global South cities [5]. In urban settings like Manila and Johannesburg, patients often view immunotherapy with skepticism, associating it with foreignness and colonial legacies of medical imposition [5,9,16]. Langwick's postcolonial perspective underscores this resistance [16], noting that biomedical interventions are often perceived as extensions of Western dominance, leading patients to prefer local healing practices like herbalism or spiritual rituals [14]. For example, in urban Brazil, patients may integrate immunotherapy with Pentecostal prayer, reinterpreting biomedical treatments through spiritual frameworks [5,9,10]. This cultural reinterpretation highlights the role of medical pluralism in urban health systems [13], where biomedical and alternative practices coexist and compete, shaping patients' health-seeking behaviors in complex ways.

Economic barriers further complicate the adoption of immunotherapy [5], particularly in low-resource urban settings. The high cost of these treatments, often exceeding $400,000 per patient, makes them largely inaccessible to most global South populations [28]. Siddiqui and Rajkumar critique the pharmaceutical industry's market-driven pricing, which prioritizes profit over equity [28], exacerbating disparities in cancer care [1]. In Nairobi, for instance, public hospitals lack the infrastructure to administer immunotherapy [5], forcing patients to rely on older, less effective treatments like chemotherapy or forego care altogether [9,25].

Even in the global North, urban minorities in cities like Chicago face similar barriers, with Manderson noting that African American communities often experience delays in accessing advanced treatments due to systemic racism and economic marginalization [15]. These findings reveal a stark divide between the scientific promise of immunotherapy and its practical accessibility [5], highlighting the need for culturally sensitive and economically feasible approaches to cancer care in urban contexts [1].

5.3. Political-Economic Analyses of Resource Allocation in Neoliberal Health Systems

The third set of findings focuses on the political-economic constraints shaping cancer care in urban settings, emphasizing the role of neoliberal transnational health governance structures in perpetuating inequities [1,19]. Neoliberalism, as Harvey defines [24], prioritizes market-driven healthcare models, leading to privatization, cost-shifting, and reduced public funding that disproportionately affect low-income urban populations. In cities like Nairobi, public hospitals are overcrowded and under-resourced, forcing cancer patients to seek costly private care or forego treatment [9,25]. Knaul et al. document the catastrophic expenditure faced by these patients, with out-of-pocket costs for cancer treatment often exceeding annual household incomes, pushing families into poverty [1,25]. The World Health Organization further notes that the economic burden of cancer, including treatment costs and lost productivity, is a major driver of health inequities in urban settings, particularly in the global South [1,26].

The findings also reveal how neoliberal policies exacerbate disparities in access to advanced treatments like immunotherapy [5,19]. In urban Brazil, for instance, the privatization of healthcare has led to a two-tiered system, where wealthy patients can access cutting-edge treatments in private clinics, while the urban poor in favelas rely on underfunded public hospitals [30]. Goss et al. highlight how this disparity is compounded by environmental factors in informal settlements [30], such as exposure to carcinogens from air pollution or contaminated water, which increase cancer risk among the urban poor, yet access to screening and treatment remains limited [1]. In the global North, similar patterns emerge: in Chicago, African American communities face delays in cancer screening due to systemic racism and economic marginalization [1], as Manderson documents [15], reflecting the pervasive impact of structural violence across global contexts [6].

Farmer's concept of structural violence provides a critical lens for understanding these inequities [6], revealing how systemic factors, such as neoliberal policies [19], racism, and poverty, shape health outcomes. In urban Mexico, Hunt notes that cancer patients often use illness narratives as a form of social empowerment, forming community networks to share resources and emotional support in the face of economic barriers [9,32]. This finding suggests a form of resistance to neoliberal constraints, aligning with Biehl's concept of postneoliberal care, where urban communities develop alternative care models to address systemic failures [34]. However, the findings also indicate that such community-based strategies are often insufficient to overcome structural barriers, particularly in the absence of policy reforms that address the root causes of inequity, such as the high cost of cancer drugs or the lack of public health funding [24,28].

5.4. Synthesis of Findings: Toward Culturally Sensitive and Equitable Cancer Care

The synthesis of these findings reveals cancer as a deeply intersectional phenomenon, shaped by the interplay of cultural meanings, biomedical advancements, and systemic inequities in urban contexts [1]. Culturally, cancer narratives reflect the diverse ontologies of urban populations, with metaphors and spiritual frameworks mediating suffering and resilience in cities like Mumbai and São Paulo [3,4,7,10]. Biomedically, immunotherapeutic paradigms offer significant promise but are contested by cultural skepticism and economic barriers [5], particularly in the global South, where medical pluralism shapes treatment decisions [13,14]. Politically and economically, neoliberal health governance perpetuates inequities, limiting access to care and exacerbating the burden of cancer on marginalized urban populations [1,19,25,30]. Together, these findings underscore the need for health interventions that are culturally sensitive, economically accessible, and systemically equitable, addressing the root causes of disparity while honoring the diverse ways urban communities experience and navigate cancer [1].

The findings also highlight the resilience of urban

populations in the face of these challenges. From community networks in Mexico to spiritual practices in Brazil, urban patients demonstrate agency in navigating pluralistic health systems and resisting neoliberal constraints [9,10,13,19,31]. However, the persistence of structural violence [6], manifested in economic barriers, systemic racism, and environmental risks, suggests that individual and community-level strategies must be supported by broader systemic changes. Future health policies should prioritize public funding for cancer care [1], reduce the cost of treatments like immunotherapy [5], and integrate cultural frameworks into medical practice, ensuring that interventions resonate with the lived realities of urban populations [2]. These insights contribute to medical anthropology's broader discourse on global health, advocating for a more equitable and culturally grounded approach to cancer care in an era of globalization [1,2].

5.5. Conflict and Integration

The diversity of these narratives also reveals significant conflicts and integration efforts within urban health systems. In Nairobi, for instance, conflicts arise when families and communities push for traditional healing practices, such as herbal remedies, over biomedical treatments, creating tensions that delay critical care and exacerbate health outcomes [9]. This conflict reflects a broader struggle between cultural beliefs and biomedical authority, as Janzen notes in his work on medical pluralism in African contexts [42], where differing epistemologies often lead to mistrust and competing care priorities. At the same time, integration occurs as patients attempt to reconcile these systems, blending spiritual rituals with hospital visits in a form of pragmatic pluralism [14]. For example, in urban Brazil, cancer patients often integrate Pentecostal prayer with chemotherapy, navigating the conflict between spiritual and biomedical frameworks to create a hybrid healing practice that aligns with their cultural identity [9,10]. This integration, however, is not without tension, as patients report feeling caught between community expectations and medical advice, highlighting the complex interplay of conflict and integration in urban cancer care [42].

The diversity of these narratives reflects the cultural hybridity of urban contexts, where migration and globalization bring together multiple healing systems [4,13]. Medical pluralism, as Leslie defines it, is a prominent theme, with urban patients blending biomedical diagnoses with traditional remedies [9,13], such as Ayurveda in India or herbalism in Brazil [14]. Naraindas and Bastos note that this pluralism is not merely pragmatic but deeply cultural, as patients reinterpret cancer through lenses of ancestral knowledge and spiritual balance [1,14]. However, the findings also reveal tensions within this pluralism: in Nairobi, for instance, patients often face pressure from family members to prioritize traditional healers over oncologists, leading to delays in biomedical treatment that can exacerbate health outcomes [9]. These cultural framings highlight the need for health interventions that respect and integrate local meanings, ensuring that cancer care is not imposed but collaboratively negotiated with urban communities [1].

The integration of immunotherapy into urban health systems also sparks notable conflicts, particularly when cultural beliefs clash with biomedical protocols [5]. In Mumbai, for instance, patients often face conflicts between oncologists' recommendations for immunotherapy and family pressures to rely on Ayurvedic treatments [5,9], leading to delays in care and strained relationships with healthcare providers [14]. Scheper-Hughes argues that such conflicts reflect deeper power imbalances in global health, where biomedical systems marginalize local knowledge, creating distrust among urban communities [43]. Conversely, integration efforts are evident in cities like São Paulo, where clinics have begun to incorporate cultural mediators to facilitate dialogue between patients and doctors, aiming to integrate immunotherapy with local practices like spiritual healing [5,10]. These mediators help patients navigate the conflict by fostering mutual understanding, allowing for a more cohesive care model that respects both biomedical efficacy and cultural values [43]. Despite these efforts, the integration remains incomplete, as economic barriers often prevent sustained access to immunotherapy [5], underscoring the interplay of conflict and integration in urban cancer care.

Economic barriers further complicate the adoption of immunotherapy [5], particularly in low-resource urban settings. The high cost of these treatments, often exceeding $400,000 per patient, makes them largely inaccessible to most global South populations [28]. Siddiqui and Rajkumar critique the pharmaceutical industry's market-driven pricing, which prioritizes profit over equity, exacerbating disparities in cancer care [1,28]. In Nairobi, for instance, public

hospitals lack the infrastructure to administer immunotherapy [5], forcing patients to rely on older, less effective treatments like chemotherapy or forego care altogether [9,25]. Even in the global North, urban minorities in cities like Chicago face similar barriers, with Manderson noting that African American communities often experience delays in accessing advanced treatments due to systemic racism and economic marginalization [15]. These findings reveal a stark divide between the scientific promise of immunotherapy and its practical accessibility, highlighting the need for culturally sensitive and economically feasible approaches to cancer care in urban contexts [1,5].

5.6. Conclusion of Findings and Results

In conclusion, the findings of this study illuminate the complex realities of cancer in globalized urban ecologies [1,33], revealing the intersections of cultural narratives [4], biomedical advancements [5], and political-economic constraints [6]. By synthesizing secondary sources through a medical anthropological lens [2], the study offers a nuanced understanding of malignant transformation, highlighting the urgent need for health interventions that bridge cultural sensitivity, scientific innovation, and systemic equity. These results set the stage for the discussion and conclusion, where the implications of these findings will be explored in greater depth, offering recommendations for future research and policy in global health.

Table 1 summarizes key cancer narratives, highlighting cultural framings, conflicts, and integration efforts in urban contexts [8,10,14,42].

Table 1. Thematic Matrix of Cancer Narratives in Urban Contexts [8,10,14,42].

City	Narrative Trope	Cultural Framing	Conflict Example	Integration Effort
Mumbai	"Karmic Imbalance"	Spiritual/Moral Disruption	Stigma as contagious condition [8]	Blending Ayurveda with biomedical care [14]
São Paulo	"Divine Test"	Pentecostal Faith	Prioritizing prayer over chemotherapy [10]	Integrating prayer with immunotherapy [10]
Nairobi	"Modern Affliction"	Urbanization/ Tradition Clash	Family pressure for herbal remedies [42]	Combining rituals with hospital visits [14]

6. Conclusions

This medical anthropological inquiry into the cultural framings of cancer has illuminated cancer in globalized urban contexts [1,33], weaving together narrative intertextuality [4], immunotherapeutic integration [5], and neoliberal resource conflicts [19]. The findings underscore cancer as a profound cultural, scientific, and systemic phenomenon that shapes the lived experiences of urban populations in cities like Mumbai, São Paulo, and Chicago [1]. By synthesizing secondary sources, this study has contributed to medical anthropology's discourse on global health, offering insights that bridge cultural meanings, scientific advancements, and structural inequities [2].

The study's findings reveal cancer as an intersectional phenomenon [1], shaped by cultural meanings, biomedical advancements, and systemic inequities. Culturally, narratives highlight how urban communities construct cancer through symbolic discourses, while biomedically, immunotherapies offer promise but are contested by cultural skepticism and economic barriers [1,4,5,11,14]. Politically and economically, neoliberal health governance perpetuates inequities [19,25,30]. Together, these findings underscore the need for health interventions that are culturally sensitive, economically accessible, and systemically equitable, addressing the root causes of disparity while honoring diverse cancer experiences [1].

The implications for medical anthropology and global health are profound, emphasizing the importance of cultural sensitivity in cancer care [1,2], equitable access to biomedical advancements [5], and systemic change to address neoliberal constraints [19]. This study also contributes methodologically by demonstrating the value of narrative-driven approaches in synthesizing interdisciplinary phenomena [41]. Future research should explore digital technologies in cancer narratives [2], adopt decolonial frameworks [44], and focus on policy recommendations to translate insights into practical interventions [38]. In conclusion, this study redefines cancer as a cultural, biomedical, and economic phenomenon, fostering dialogue on equitable cancer care

in an era of globalization [1].

This study also contributes to medical anthropology's methodological discourse by demonstrating the value of descriptive, narrative-driven approaches in synthesizing complex, interdisciplinary phenomena [2]. The use of narrative synthesis and thematic analysis allowed for a holistic exploration of cancer [1,39,40], bridging cultural, biomedical, and economic perspectives in a way that empirical studies might not achieve within the same scope [41]. However, as noted in the Limitations section, the reliance on secondary sources and the urban-centric focus constrain the study's generalizability, suggesting that future research should incorporate primary ethnographic fieldwork and explore non-urban contexts to capture a broader range of cancer experiences [35].

Looking forward, several directions for future research emerge from this study. First, there is a need to explore the role of digital technologies in shaping cancer narratives [1], particularly in urban settings where social media and telemedicine are transforming health communication [2]. For instance, how do online support groups influence cultural ontologies of cancer among urban youth in cities like Chicago [1,3]? Second, future studies should adopt decolonial and intersectional frameworks to address the colonial legacies and intersecting oppressions that shape cancer care [1], as suggested by Mignolo and Crenshaw [36,37]. This could involve centering Indigenous knowledge systems in global South cities or examining how race, gender, and class intersect to influence cancer outcomes in urban minorities [15]. Third, research should focus on developing actionable policy recommendations, potentially through implementation science [38], to translate theoretical insights into practical interventions that address the economic and systemic barriers identified in this study [25]. For example, how can community-based models of care be scaled to improve access to immunotherapy in low-resource settings [5]?

In conclusion, this study redefines cancer as a cultural, biomedical, and economic phenomenon within the complex ecologies of globalized urban centers [1,33], offering a nuanced understanding of malignant transformation that bridges disciplinary divides. By synthesizing ethnographic narratives [9], biomedical discourses [18], and political-economic critiques [6], it fosters dialogue on equitable cancer care [1], advocating for interventions that honor cultural diversity while addressing systemic inequities. Medical anthropology remains a vital discipline in this endeavor [2], providing the tools to navigate the intersections of meaning, science, and power in global health. As we move forward, the challenge lies in translating these insights into policies and practices that ensure cancer care is accessible, culturally relevant, and just for all urban populations, paving the way for a more equitable future in health governance [1].

Author Contributions

Conceptualization, H.J. and M.F.; methodology, H.J. and Z.J.; software, M.F.; validation, H.J., Z.J., E.H. and M.F.; formal analysis, H.J. and A.H.; investigation, H.J., M.F., A.H. and Z.J.; resources, H.J.; data curation, M.F. and Z.J.; writing—original draft preparation, H.J., Z.J. and M.F.; writing—review and editing, M.F., S.K. and N.H.; visualization, M.F., N.H. and S.K.; supervision, H.J.; project administration, H.J.; funding acquisition, Z.J. and H.J. All authors have read and agreed to the published version of the manuscript.

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This study relies solely on secondary data from existing peer-reviewed ethnographic studies, biomedical reviews, and policy reports, with no new data generated. The analyzed datasets are publicly available through databases such as PubMed, JSTOR, and the World Health Organization archives, accessible via their respective websites. Due to the nature of secondary analysis, no privacy or ethical restrictions apply, and no additional data sharing is required.

Conflicts of Interest

The authors declare no conflict of interest.

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