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Review Article

Care Practices used by Women with Cancer in Kleinman's Health Care Sectors: an Integrative Review

Andriele Ferreira Falcão[1], Stefanie Griebeler Oliveira[2], Fernanda Eisenhardt de Mello[3], Karen Soares Porto[4], Ágata Fernandes Justin[5]*

[1] Bachelor's Degree. Hospital Bruno Born, RS, Brasil; orcid.org/0009-0002-8798-7786
[2] PhD. Universidade Federal de Pelotas, RS, Brasil; orcid.org/0000-0002-8672-6907
[3] Master. Universidade Federal de Pelotas, RS, Brasil; orcid.org/0000-0003-3423-5599
[4] Master. Universidade Federal de Pelotas, RS, Brasil; orcid.org/0000-0002-5607-6982
[5] Bachelor's Degree. Universidade Federal de Pelotas, RS, Brasil; orcid.org/0009-0007-3814-6944

*** Corresponding author:** agata_justin@hotmail.com

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Abstract

Objective
To understand, based on the scientific literature, the care practices used by women with cancer in different health care sectors according to Arthur Kleinman's theoretical framework.

Methods
An integrative review was conducted using the SciELO, LILACS, Scopus, and CINAHL databases, with search strategies combining terms related to health, women, cancer, traditional medicine, and folk medicine using the Boolean operators AND and OR. A total of 5,072 records were identified, and after study selection and assessment of reporting quality based on items from the Consolidated Criteria for Reporting Qualitative Research, 14 articles were included in the final sample. Data were analyzed using directed content analysis guided by Arthur Kleinman's theoretical framework.

Results
The studies showed that women with cancer use care practices in the popular, folk, and professional sectors, with the professional sector predominating, especially through cancer treatments and physical therapy. In the popular sector, self-care, spirituality, family support, diet, and the use of medicinal plants were prominent. In the folk sector, practices such as *garrafadas* (traditional bottled remedies), herbal teas, and advice from traditional healers or prayer healers were identified. The intersections between sectors showed that these forms of care may be used concurrently, as complements to one another, or over time throughout the therapeutic itinerary.

Conclusion
Women with cancer were found to use care practices in the professional, popular, and folk sectors, with biomedical care predominating but with spiritual, family-based, traditional, and self-care practices also present. The findings reinforce the need for comprehensive, humanized, and culturally sensitive nursing care capable of recognizing the coexistence and intersections of different forms of care throughout the course of illness and treatment.

Keywords
Medicine, Traditional; Neoplasms; Women; Complementary Therapies; Informal Sector.

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Introduction

Cancer can be understood as a disease characterized by the uncontrolled growth of abnormal cells that evolve over time through processes of natural selection.[1] Data from a study using a feminist approach show that cancer ranks among the three leading causes of premature death among women in most countries worldwide.[2] By 2040, projections for the cancers with the highest incidence among women, considering demographic changes alone, follow the pattern observed in 2020: breast cancer (364,000), lung cancer (114,000), uterine cancer (99,000), and melanoma (92,000). Colorectal cancer (72,000) then ranks fifth in frequency.[3]

Data from the Pan American Health Organization identify breast cancer as the leading cancer in terms of incidence and mortality among women, followed by lung, colorectal, cervical, and pancreatic cancers, underscoring the magnitude of this health problem for health systems in the region.[4] Beyond its clinical and physiological repercussions, cancer causes emotional distress, bodily changes, effects on family life, spiritual uncertainty, and everyday challenges that permeate the illness experience.[5]

Accordingly, understanding health care solely through the biomedical model is insufficient. The experience of cancer often leads women to seek multiple formal and informal therapeutic resources that are used simultaneously throughout the therapeutic itinerary. This pattern shows that coping with the disease takes place not only within health services but also within family, religious, cultural, and community relationships.[6]

To understand this plurality of practices, the theoretical framework adopted was Arthur Kleinman's health care system, according to which care is organized into three interdependent sectors: the popular sector, associated with self-care, family support, and everyday knowledge; the folk sector, associated with specialists who lack formal recognition, such as *benzedeiros* (traditional healers who use blessings), traditional healers, and prayer healers; and the professional sector, corresponding to the institutionalized biomedical model.[7] This perspective makes it possible to analyze the therapeutic pluralism present in the illness experience, as well as the cultural negotiations that permeate women's care choices and practices.

Spiritual practices are an important component of the health care sectors, particularly in chronic illness. A study of people with cancer in sub-Saharan Africa demonstrated that prayer, counseling, and culturally contextualized rituals contribute to reducing anxiety, strengthening hope, and improving quality of life and are recognized as part of comprehensive cancer care.[8]

Consistent with these findings, a review of spirituality as a coping strategy among women with breast cancer demonstrated that religiosity and spirituality permeate the entire illness experience, fostering comfort, meaning-making, and resilience. Manifested primarily through prayer and faith, these practices show that the therapeutic itinerary involves needs that extend beyond biological cure, requiring a nursing approach sensitive to the emotional, family, and spiritual dimensions of suffering.[9]

Recent studies show that spiritual practices and support networks play an important role in coping with cancer, contributing to reducing anxiety, strengthening hope, and finding new meaning in suffering.[8-10] Religiosity and spirituality have also been described as resources that help women with cancer make sense of illness and sustain emotional coping strategies.[8,10] At the same time, medicinal plants, body-based practices, and complementary therapies are used, showing that health care extends beyond pharmacological therapy.[11-12] At the institutional level, Integrative and Complementary Health Practices (PICS)[13-15], incorporated into Brazilian public policies, have also been recognized as adjuncts to the management of pain, anxiety, insomnia, and other discomforts associated with cancer treatment.[11-12]

However, beyond officially recognized practices, lay and traditional forms of knowledge persist and continue to permeate women's therapeutic itineraries, although they remain underexplored in the scientific literature.[16-17]

A gap can therefore be identified in the scientific literature regarding a broader understanding of the care practices used by women with cancer, particularly when analyzed from the perspective of the different health care sectors and their sociocultural interfaces. Understanding these practices may contribute to strengthening nursing care that is culturally sensitive, comprehensive, and oriented toward recognizing the therapeutic pluralism present in women's experience of cancer.

Therefore, the objective was to understand, based on the scientific literature, the care practices used by women with cancer in different health care sectors according to Arthur Kleinman's theoretical framework.

Method

Study design

An integrative literature review was conducted, a method that enables the synthesis and broader analysis of knowledge produced about a given phenomenon by bringing together findings from studies using different approaches and contributing to an understanding of gaps and trends in the scientific literature.[18-19] The six

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methodological stages recommended for integrative reviews were followed in this study: formulation of the research question, definition of inclusion and exclusion criteria, literature search, data extraction, critical analysis, and knowledge synthesis.[18]

The review question was formulated using the PICo framework, considered appropriate for investigations involving qualitative phenomena,[20] and was defined according to the following components: P (Population) – women with cancer; I (Interest) – care practices; and Co (Context) – health services at all levels (primary, outpatient, and hospital care). Accordingly, the following research question was established: what care practices are used by women with cancer who receive treatment at health services described in the literature?

Inclusion and exclusion criteria

Original qualitative studies published in Portuguese, Spanish, or English, with no publication date restrictions, that involved women with cancer and described their care practices, which could be related to the popular, folk, or professional sectors, were included. Practices reported by study participants could include those referred to as popular practices, traditional medicine, complementary therapies, self-care, spirituality, or professional care. Qualitative studies were included because this design was considered to provide greater insight into women's experiences, meanings, and narratives regarding illness and the care practices they used throughout their therapeutic itinerary.

Review articles, quantitative studies, editorials, theses, dissertations, conference proceedings, documentary studies, and studies whose participants were not women undergoing cancer treatment or living with cancer were excluded.

Information sources and databases

The literature search was conducted in Latin American and Caribbean Health Sciences Literature (LILACS), Scientific Electronic Library Online (SciELO), Scopus, and Cumulative Index to Nursing and Allied Health Literature (CINAHL). These databases were selected because they were considered to include qualitative studies related to the illness experience, cultural care practices, and therapeutic itineraries, all central to the focus of this study.

Search strategies

Searches were conducted in June 2026 by the first, second, third, and fifth authors of the study. The search identified 5,072 records across the databases, 387 of which were duplicates, leaving 4,685 records for title and abstract screening. The subject headings and keywords used were health, women, cancer, traditional medicine, and folk medicine. The Boolean operators AND and OR were used. The subject headings were tested and yielded the results by database shown in Table 1.

Table 1. Search strategies and records retrieved

Database	Search strategy	Records retrieved
SciELO	(saúde) AND (mulheres) AND (câncer) AND (medicina tradicional) OR (medicina popular)	1,360
LILACS	(saúde) AND (mulheres) AND (câncer) AND (medicina tradicional) OR (medicina popular)	3,559
CINAHL	health AND women AND cancer AND traditional medicine OR *folk* medicine	113
Scopus	(KEY (health) AND KEY (women) AND KEY (cancer) AND KEY (traditional medicine) OR KEY (*folk* medicine))	40
Total records		5,072
Duplicate records		387
Records for screening		4,685

Source: Prepared by the authors, 2026.

Different search strategies using specific subject headings were tested, but some combinations did not yield satisfactory results. For example, adding the subject heading Pesquisa Qualitativa yielded no results. Therefore, broader subject headings and alternative terms, such as saúde, mulheres, câncer, medicina tradicional, and medicina popular, were used to increase search sensitivity and retrieve more potentially eligible studies.

The Boolean operator OR was used to broaden the results because it would retrieve mentions of either medicina popular or medicina tradicional.

Study selection

Initially, all records retrieved from the databases underwent title and abstract screening to assess their relevance to the study focus and the previously established criteria. Many titles were excluded at this stage because they referred to quantitative studies and/or studies on breast cancer prevention (mammography, breast self-examination, clinical breast examination) or cervical cancer prevention (knowledge, adherence, results, etc.).

The 55 potentially eligible studies proceeded to full-text review, which was also conducted independently by two reviewers. Disagreements regarding inclusion or exclusion were discussed between the reviewers and, when necessary, referred to a third reviewer until consensus was reached.

Of these, 24 proceeded to the reporting quality assessment stage. The other 31 were excluded because they did not mention care practices and focused more on feelings and sensations related to living with some type of cancer, without mentioning care practices they accessed during their therapeutic itinerary.

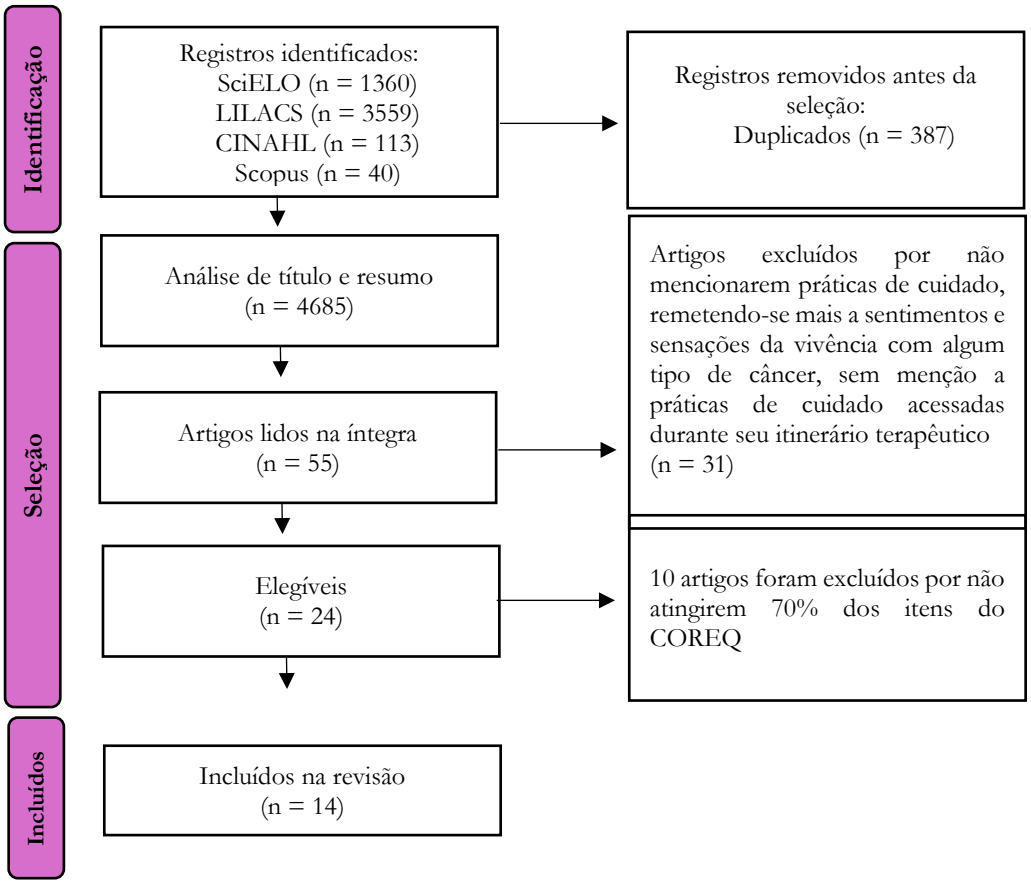

Figure 1. The flow diagram adapted from the PRISMA-ScR model[21] illustrates the identification, screening, and inclusion stages.

Assessment of reporting quality

The reporting quality of the articles was assessed based on the items of the Consolidated Criteria for Reporting Qualitative Research (COREQ).[22] This instrument was selected because it is an EQUATOR checklist that provides guidance on important and essential information for reporting articles, particularly in the Methods sections of qualitative research articles, which ensures the possibility of reproducibility, as shown in Table 2. The Brazilian validation[23] of this instrument showed a significant improvement in the quality of qualitative research articles. Fourteen publications achieved a minimum score of 70%; these were analyzed and their data were extracted.

Table 2. Assessment of reporting quality using COREQ.

Questões*/Autor/Ano	Almeida et al, 2015	Gázola et al, 2017	Macedo et al, 2018	Almeida et al, 2022	Salimena et al, 2012	Rosa e Radünz, 2013	Barradas et al, 2022	Duque et al, 2023	Pereira et al, 2024	Oliveira et al, 2024	Brilhante et al, 2025	Ramírez-Perdomo, 2018	Cunha et al, 2019	Castañeda, Buriticá, 2020	Soares et al, 2019	Maree et al, 2014	Mensah et al, 2024	Jaman-Mewes et al, 2014	Ferreira et al, 2015	Soares et al, 2016	Machado et al, 2017	Mårtink et al 2020	Souza et al, 2021	Salazar et al, 2025
Q1	N	N	N	N	N	N	N	N	N	S	S	N	S	N	N	S	S	N	S	N	N	S	S	N
Q2	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q3	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q4	N	S	N	N	N	N	N	N	N	N	S	N	S	N	N	N	N	N	N	N	N	S	N	N
Q5	N	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	S	N	S	N	N	N	S	N
Q6	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q7	S	S	S	S	S	S	S	S	S	S	S	S	S	N	N	S	S	S	S	S	S	S	S	S
Q8	N	N	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	S	N
Q9	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q10	S	S	N	S	N	S	N	S	N	S	N	N	S	S	S	S	S	S	S	N	S	S	S	S
Q11	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q12	S	S	S	S	S	S	N	S	S	S	S	S	S	S	S	S	S	S	S	S	N	S	S	S
Q13	S	N	N	N	N	N	N	N	N	S	N	N	S	S	S	S	S	S	S	S	S	S	S	S
Q14	S	S	N	S	S	N	S	S	N	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q15	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q16	S	S	S	S	S	S	S	N	S	S	S	S	S	N	S	S	S	S	N	S	S	S	S	S
Q17	N	S	N	N	N	N	N	N	N	S	N	N	S	S	N	N	N	N	N	N	S	N	N	N
Q18	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q19	S	S	S	S	S	S	S	N	N	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S	N/A	N/A
Q21	N	S	N	S	N	N	S	N	N	N	N	S	S	N	S	S	S	S	S	N	S	S	S	S
Q22	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q23	N	N	N	N	N	S	N	N	N	N	N	N	S	N	N	S	S	S	N	N	N	S	S	N
Q24	N	N	N	N	N	N	N	S	N	N	N	N	N	S	N	S	N	N/A	S	N	N	N	S	N
Q25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N	N/A	N	N/A	N/A	S	N/A	S	N	N	S	N/A	N/A	N/A	N/A	N/A
Q26	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q27	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	S	N/A	S	N/A	N/A	S	N/A	S	S	N/A	S	N/A	N/A	N/A	N/A	N/A
Q28	N	N	N	N	N	S	N	N	N	N	N	N	S	N	N	S	S	S	N	N	N	S	S	N
Q29	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q30	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q31	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Q32	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Total	69 %	76 %	59 %	69 %	62 %	69 %	62 %	62 %	55 %	79 %	71 %	65 %	90 %	71 %	70 %	87 %	84 %	79 %	81 %	65 %	72 %	87 %	93 %	72 %

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* **Domain 1 – Research team and reflexivity:** Q1. Does the article report which author conducted data collection? Q2. Does it report the researcher's credentials? Q3. Does it report the authors' occupations at the time of the study? Q4. Does it report the author's sex? Q5. Does it report the researcher's experience or training? Q6. Does it report whether any type of relationship was established before the study began? Q7. Does it report what the participants knew about the researcher? Q8. Does it report which characteristics of the researcher/interviewer were disclosed?
Domain 2 – Study design: Q9. Does the article report the methodological orientation underpinning the study? Q10. Does it report how participants were selected (sampling)? Q11. Does it report how participants were approached? Q12. Does it report how many participants were included in the study? Q13. Does it report how many people refused to participate or withdrew and the reasons for doing so? Q14. Does it report where the data were collected? Q15. Does it report whether anyone other than the participants was present during data collection? Q16. Does it report the sample's sociodemographic characteristics or the date of data collection? Q17. Does it report whether the authors provided questions, instructions, or guides and, if so, whether these were pilot tested? Q18. Does it report whether repeat interviews were conducted? Q19. Does it report whether audio or visual recording was used? Q20. Does it report whether field notes were made during and/or after the encounter? Q21. Does it report the duration of the encounter? Q22. Does it report whether data saturation was discussed? Q23. Does it report whether transcripts were returned to participants for comments or corrections?
Domain 3 – Analysis and findings: Q24. Does the article report the number of data coders? Q25. Does it report whether the authors provided a description of the coding tree? Q26. Does it report whether themes were identified in advance or derived from the data? Q27. Does it report which software, if applicable, was used to manage the data? Q28. Does it report whether participants provided feedback on the findings? Q29. Were participant quotations presented to illustrate the themes/findings? Was each quotation identified by a code? Q30. Does it report whether there was consistency between the data presented and the findings? Q31. Were the major themes clearly presented in the findings? Q32. Is there a description of different cases or discussion of minor themes?

** Y = yes; N = no; N/A = not applicable.
Source: Prepared by the authors, 2026.

Data extraction
For data extraction, a table was used to organize information collected from the articles on publication year, country, journal, field, women's race and age, cancer type, and care practices reported or mentioned by the women.

Data analysis and synthesis
Directed content analysis was used to analyze the data extracted from the articles. The primary goal of this approach is to validate or conceptually extend an existing theoretical framework or theory. In addition, it can generate predictions about variables of interest or relationships among them, contributing to the initial definition of the coding scheme and the identification of relationships among codes; this application is known as deductive categorization.[24]
The concepts applied to the identified care practices corresponded to the health care sectors proposed by Arthur Kleinman: the popular sector, the folk sector, and the professional sector.[7] The analytical process continued with a reading of the care practices column in the data extraction table. When, for example, the use of herbal teas was mentioned, the context in which they were used was examined to determine whether instructions for their use or preparation originated within the family—in which case the practice was classified in the popular sector—or whether the practice had been recommended by a traditional healer or another traditional practitioner—in which case it was classified in the folk sector. Intersections between sectors that occurred concurrently at times reported by study participants were also considered, along with their use of different sectors over time according to their experience of cancer treatment.

Results

A caracterização dos estudos incluídos nesta revisão está apresentada no Quadro 3. Observa-se que a temática foi investigada em diferentes períodos e contextos nacionais, com predomínio de estudos desenvolvidos no Brasil. Também foram identificadas produções realizadas em outros países, como Colômbia, Chile, Zâmbia, Gana e México.

Table 3. Characteristics of the included studies

Author/Year	Journal	Study country	Field	Women's race	Women's age
Gazola *et al.*, 2017[25]	Revista de Terapia Ocupacional da Universidade de São Paulo	Brazil	Physical therapy	Not reported	18–35 years
Oliveira *et al.*, 2024[26]	Revista Mineira de Enfermagem	Brazil	Nursing	7 Brown (parda), 6 White, and 2 Black	Mean age: 50.9 years
Brilhante *et al.*, 2025[27]	Saúde e Sociedade	Brazil	Multidisciplinary	Not reported	24–54 years
Cunha *et al.*, 2019[28]	Escola Anna Nery Revista de Enfermagem	Brazil	Nursing	Not reported	43–65 years
Castañeda e Buriticá, 2020[29]	Investigaciones Andina	Colombia	Nursing	Not reported	Not reported
Soares *et al.*, 2019[30]	Avances en Enfermería	Brazil	Nursing	3 Brown, 1 Black, and 1 White	25–73 years
Maree, Cur e Kaila, 2014[31]	International Journal of Gynecological Cancer	Zambia	Nursing	Not reported	34–75 years
Mensah *et al.*, 2024[32]	BMC Complementary Medicine and Therapies	Gana	Nursing	Not reported	34–77 years
Jaman-Mewes e Rivera, 2014[33]	Aquichan	Chile	Nursing	Not reported	Mean age: 56.2 years
Ferreira, Salazar e Peruchi, 2015[34]	Psicologia Hospitalar	Brazil	Psychology	Not reported	39–64 years
Machado, Soares e Oliveira, 2017[35]	Physis: Revista de Saúde Coletiva	Brazil	Nursing	Predominantly Brown	30–70 years
Mairink *et al.*, 2020[36]	Escola Anna Nery Revista de Enfermagem	Brazil	Nursing	Not reported	18–40 years
Souza *et al.*, 2021[37]	Aquichan	Brazil	Nursing	Not reported	43–72 years
Salazar *et al.*, 2025[38]	Revista de Investigación en Salud	Brazil, Colombia, and Mexico	Nursing	Not reported	41–70 years

Source: Prepared for this study.

The three health care sectors used by women with cancer are presented below: popular, folk, and professional.

Popular sector

Among the care practices reported by study participants that originated in the popular sector and circulated among family members, friends, neighbors, and the community were: diets excluding meat and including fruits and vegetables that could improve symptoms; preparation of detox juices; use of teas learned from family members or friends; bathing practices as a way of saying goodbye to a body part that would be surgically removed or avoiding mirrors after surgery; practices involving faith, prayer, reading, dialogue with the divine, and church attendance; and caring for plants or contact with nature.

Study[28] found that dietary practices involved selecting certain foods that, although not chosen specifically to

relieve chemotherapy symptoms, were described by the women as a way to prevent, alleviate, or reduce unwanted effects and adverse reactions during chemotherapy. These foods included green juices, perceived as a way to strengthen the immune system. They could contain ora-pro-nóbis, mint, parsley, lemon, bananas, apples, papaya, ginger, etc. Mate tea was also mentioned for oral hydration. Passion fruit juice was used to calm the mind and keep the body more relaxed. Another study[29] highlighted one participant's aversion to meat and her choice of vegetables and fruits in her daily meals.

One study[25] showed that, while bathing, one participant performed a kind of farewell ritual for her breast before surgery, crying intensely and trying to imagine what the following day would be like. Another study[27] described a postoperative practice in which the participant cried while bathing and avoided looking at herself in the mirror.

Regarding religious or spiritual practices, study[26] showed that the women reported that spirituality was like a force everyone possesses and that each woman needs to discover within herself, regardless of religion. Faith was understood as spiritual uplift and a way of coping that made the process easier. From the women's perspective, dialogue with the divine could occur anywhere and was not restricted to the church; according to study[29], it was associated with prayer, Bible reading, and spiritual reflection. It was also noted that the women, particularly Christians, found meaning in their illness in the belief that spirituality could be strengthened and that this could help with treatment. Another relevant aspect of faith practices, identified in study[35], was viewing God as a living physician and attributing advances in conventional medicine to God's will. Hope was highlighted in study[37], as was trust in physicians, based on the belief that there is something between Earth and Heaven.

Finally, regarding caring for plants and contact with nature identified in study[28], participants reported that these practices reduced mental fatigue and gave them an opportunity to move to an environment outside the confines of their homes, where their daily routines and interactions took place. In this sense, greenery represents a respite.

Folk sector

Among the practices used in the folk sector, based on guidance or interventions from traditional healers and specialists in these practices, were: foods that could contribute to recovery, such as peanuts, vegetables, and fish; removal of signs of cancer through consultations; consultations with traditional medicine practitioners advertised on the radio with promises of curing cancer; seeking herbal teas from traditional healers; mixtures of herbs and foods recommended by healers; naturopathy involving natural foods and physical exercise; topical application of ointments to the skin, holy water, and anointing oil; and spiritual surgery.

Study[29] showed that women placed great importance on traditional treatments and lay recommendations concerning foods that could be consumed by people with cancer and could aid recovery. They also recognized aloe vera gel as a treatment for burns to protect the skin from radiation therapy. Study[31] also mentioned the use of herbs by a mother and son. Another practice identified was consulting traditional healers to remove signs of cervical cancer.

Study[32] identified the media as a means of disseminating information about traditional medicine and its use in breast cancer treatment. On the radio, traditional healers and users of traditional medicine claimed that medications were effective; herbalists and users participated in the program by providing testimonials, thereby informing listeners about herbal medicines.

Mixtures of herbs with natural, healthy foods constituted treatment modalities, and herbalists advised that herbs should be added to daily meals or boiled into a mixture to be drunk as the remedy. Another method of using herbs involved applying medicines and ointments to the skin supplied by traditional medicine practitioners, who provided instructions on their preparation and application, such as cream applied to the affected area of the breast or a towel soaked in an herbal decoction and used to massage the breast.[32]

The use of naturopathic methods was also identified in study[32], in which a healthy diet, physical exercise, and sufficient rest were recommended as treatment to reduce a breast lump.

Seeking care from a spiritual healer was also identified; the healer provided holy water to drink and anointing oil to massage the chest.[32] In another study[37], the patient sought spiritual surgery before undergoing physical surgery, reinforcing her sense of being in good health before the physical surgery.

Professional sector

Care practices originating in the professional sector included chemotherapy, brachytherapy, radiation therapy, and consultations with physicians and physical therapists. Chemotherapy prompted observations and a reframing of the body in physical, mental, and emotional terms in relation to treatment, including the reorganization or disruption of daily life[27], hair loss[29,32,36,38], and symptoms such as nausea, weakness, dyspareunia, itching of the arms, lack of thirst[27,36], and bone pain.[38] Brachytherapy caused painful moist desquamation[31], particularly because of the antiseptic used before the procedure. Radiation therapy[29] caused nail damage, tooth loss, anemia, weight loss, burns, worsening pain, and drowsiness.

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Medical consultations provided support from the cancer investigation stage onward and offered possibilities for controlling symptoms such as pain.[36] Consultations with the physical therapist[27] focused particularly on sexuality and involved massage, laser therapy, and greater awareness of internal organs.
Study[24] reported a lack of sexual desire for a partner during chemotherapy. In another study[27], this complaint was alleviated through treatment of dyspareunia with physical therapy and vaginal laser therapy, with reports of marked improvement in sexuality. It was also reported that physical therapy promotes greater awareness of the pelvic area.

Intersections among the popular, folk, and professional sectors

The intersection between the popular and folk sectors occurred through encouragement from family members or friends who already used traditional medicine and emphasized its effectiveness. Study[32] shows that the family circle is one of the main sources of information and trust regarding traditional medicine in cancer treatment.
Among the practices that emerged from women's accounts in the studies and involved an intersection between the professional and popular sectors were: dialogue with the divine, both when using medications and undergoing surgery; use of religious objects during biomedical procedures; the belief that treatment was 50% conventional and 50% dependent on one's own state of mind; association of something familiar with receiving chemotherapy; and separation from a body part, viewed as culturally acceptable in society as a consequence of conventional treatment, such as mastectomy.
Study[26] identifies faith as being present during chemotherapy; patients engage in practices such as undergoing the procedure with a rosary in hand and praying and talking with Jesus to calm themselves. It was also observed that, during surgical procedures, patients imagined that the blood of Christ was present at that moment and that physicians were merely instruments of Jesus. In addition, the findings indicate that patients who turn to faith focus on the belief that, if the disease prevails, they will go to a better place. Study[28] identified faith as confidence in being able to go through the treatment process, as patients relied on listening to music or reading a Gospel to calm themselves. Similarly, study[34] reports that Spiritist doctrine gives patients faith, as they believe that half of treatment comes from medicine and the other half from spiritual support.
Study[27] shows that hair is part of womanhood and is a woman's charm; during chemotherapy, women lose their hair, eyebrows, and eyelashes and become completely disfigured, no longer identifying themselves as wives and women, but only as patients undergoing treatment.
The care practices identified at the intersection of the folk and professional sectors reflected the movement of women with cancer between these sectors, motivated by information about traditional medicine disseminated on the radio, as well as by financial considerations, access to treatment, the noninvasive nature of the treatment, and its therapeutic effects, since traditional medicine was more accessible, less costly, and entailed fewer adverse effects. In contrast, conventional medicine involved a longer treatment process, as tests were required to establish a diagnosis.
Accordingly, the intersection could occur concurrently or over time: traditional treatment could be used first and conventional treatment sought afterward; both could be used together as complementary approaches; or women could leave conventional medicine because of side effects and turn to traditional medicine, which was perceived as less aggressive. Traditional medicine could be discontinued for two reasons: advice from health professionals to discontinue its use or the perception of no improvement.
Study[32] shows that patients initially choose traditional medicine because of its lower cost and the perception that it is more effective in addressing the cause of the disease—for example, by reducing a breast lump and thereby eliminating the need for mastectomy—as well as because its practices are less invasive and faster, since traditional medicine centers do not require the battery of laboratory and imaging tests that delay hospital care. The same study[32] reports that some health professionals in conventional care discouraged the use of traditional medicine because they feared it could interfere with the effectiveness of hospital treatment, and that one patient reported that the herbal cream she had used was ineffective.
Care practices were identified in all three sectors: in the popular sector, through the nuclear family and religiosity; in the folk sector, through consultations with prayer healers or traditional healers and the prescription of *garrafadas* and herbal teas; and in the professional sector, through conventional diagnosis and treatment. These practices could occur concurrently, complement one another, or be used at different points over time. Study[30] showed that there is a plurality of care systems surrounding the patient, which are used not antagonistically but concurrently and as complementary forms of care. In other words, patients use herbal teas, are devoted to God, have faith, attend outpatient clinics for biopsies, use health centers and hospitals, use *garrafadas*, and consult prayer healers.
For better visualization and organization of the information on the health care sectors accessed by women undergoing cancer treatment, Figure 2 is presented. The biomedical model is clearly central, although demands for user embracement and humanized care also permeate these forms of care.

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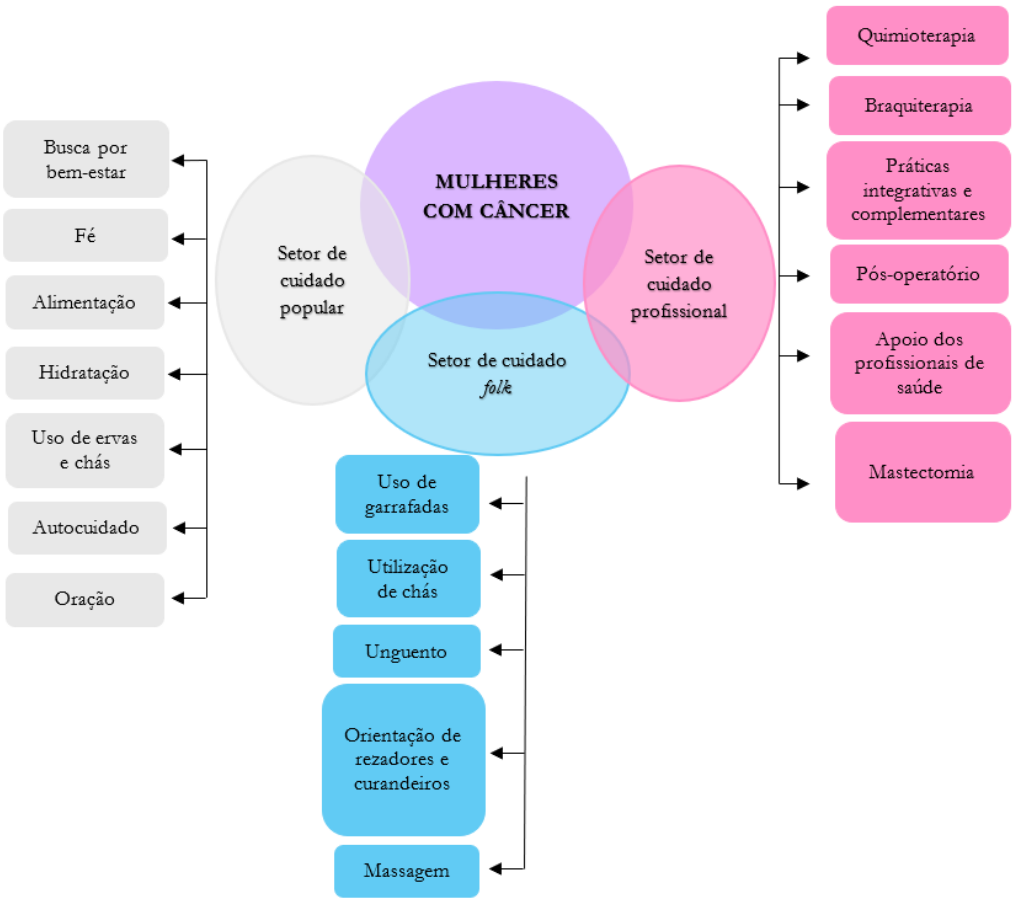

Figure 2. Mind map of care practices used by women with cancer by health care sector.
Source: Prepared for this study.

Discussion

This integrative review showed that the care practices used by women with cancer are not limited to the professional sector but span different ways of coping with illness, revealing the coexistence of the popular, folk, and professional sectors.[7] Although the professional sector predominated, especially through biomedical treatments, consultations, tests, therapeutic procedures, and physical therapy follow-up, the findings show that the experience of cancer involves needs that extend beyond the clinical management of the disease, including emotional support, spirituality, family relationships, traditional knowledge, self-care, and maintaining well-being in everyday life.

The persistence of cancer as a public health problem, with impacts that extend beyond its biological repercussions and affect body image, family life, sexuality, and social relationships, reinforces the relevance of examining care from the perspective of the sectors proposed by Kleinman, recognizing that coping with the disease involves both biomedical practices and family, community, cultural, and spiritual resources.[4] In the Brazilian context, epidemiological data reinforce the importance of studies that address cancer as a biological, social, and cultural phenomenon.[39]

The predominance of the professional sector in the studies analyzed demonstrates the centrality of the biomedical model in cancer treatment, although such practices may cause physical discomfort, bodily changes,

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and emotional suffering in women's daily lives. Professional care needs to go beyond technical aspects by considering each woman's individual circumstances and attending to the psychosocial repercussions of illness through attentive listening[40], since treatments such as chemotherapy produce physical symptoms and emotional impacts that reinforce the need for sensitive and continuous care.[41]

In addition to physical therapy follow-up, nursing plays a strategic role by maintaining close contact with women and their families and providing health education, symptom management, and emotional support throughout treatment, thereby contributing to improvements in women's psychological well-being and quality of life.[42] Individualized guidance and psychological support likewise promote understanding of the disease and treatment adherence[43], so nursing care should not be limited to the technical dimension but should encompass the experiences, questions, and beliefs that accompany women during treatment.

In the popular sector, the findings of this review showed the presence of practices developed in everyday life and shared among family members, friends, neighbors, and the community. Diet, the use of herbal teas and medicinal plants, spirituality, prayer, family support, body care, and seeking well-being are forms of care that are part of women's lives before, during, and after cancer treatment. These practices should not be interpreted solely as alternatives to health services, but as coping resources that provide meaning, comfort, and continuity of care. Traditional medicinal knowledge can be transmitted across generations through everyday interaction, observation, and community participation.[44] Similarly, knowledge of medicinal plants circulates through family and community relationships and is preserved through oral tradition and everyday experience.[45] In this process, family members such as parents and grandparents, as well as other members of the close social network, play an important role in maintaining and transmitting this knowledge.[11]

The folk sector was associated with traditional practices mediated by people socially recognized as possessing specific forms of care knowledge, such as *benzedeiros*, traditional healers, prayer healers, or other traditional practitioners. *Garrafadas*, prayers, the guided use of medicinal plants, herbal teas, and spiritual practices show the persistence of traditional knowledge in coping with illness, although these practices were less represented than those in the professional sector. In many contexts, these practices are sustained by community trust, oral tradition, and the social recognition of practitioners who occupy an important symbolic role in care. *Garrafadas* are described as artisanal preparations made by combining medicinal plants and other natural ingredients.[16] This type of preparation also reflects the persistence of traditional knowledge related to the combined use of natural resources.[46] The persistence of these practices demonstrates the strength of community trust and the social recognition of traditional practitioners in health care.[47]

Spirituality also emerged as a dimension that cuts across the care sectors, as it may appear in the popular sector through individual prayer, faith, and family support; in the folk sector when associated with prayer healers or traditional practices; and in the professional sector when recognized by the health care team as an important dimension of comprehensive care. In the context of cancer, spirituality may contribute to making sense of illness, strengthening hope, reducing anxiety, and coping with suffering. Spiritual practices, such as prayer, counseling, and culturally contextualized rituals, may contribute to emotional comfort and improved quality of life among people with cancer.[8]

Religiosity may also help women with cancer sustain hope, find new meaning in suffering, and cope with the uncertainties of treatment.[10] Thus, recognizing spirituality as a care practice does not mean replacing biomedical treatment but rather understanding that many women use faith and religiosity as sources of emotional support during treatment.

Another relevant aspect concerns the sociodemographic gaps observed in the included studies, particularly regarding participants' race/skin color. The absence or insufficient reporting of this information limits more in-depth analyses of inequalities in women's experience of cancer, since race/skin color, income, education, geographic context, and access to health services influence the time from diagnosis to treatment, continuity of care, and conditions for coping with the disease. Brown and Black women living in rural areas, facing financial difficulties, and with less access to information are more vulnerable to developing cervical cancer.[48] In addition, profiles indicating greater social vulnerability tend to be associated with longer intervals between diagnosis and initiation of treatment.[49] Thus, the lack of sociodemographic data limits understanding of how different women experience cancer and access the health care sectors.

The professional approach, therefore, needs to recognize that women do not come to health services detached from their histories, beliefs, family ties, community experiences, and care practices they have already developed. When these practices are silenced, disregarded, or judged, distance may develop between women and health professionals, making communication about the use of herbal teas, medicinal plants, *garrafadas*, and other traditional practices more difficult. In contrast, attentive listening allows the team to identify potential risks, interactions with treatment, meanings attributed to care, and safe ways to discuss these practices. Resistance or lack of interest among health professionals toward popular and traditional practices may constitute a barrier to comprehensive care.[11] Health professionals therefore need to develop a culturally sensitive stance that is open

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to therapeutic dialogue.
Finally, the findings indicate that the popular, folk, and professional sectors are not isolated, fixed, or mutually exclusive categories, but intersect throughout the course of illness and treatment.[7] The same practice may take on different meanings depending on the context: the use of medicinal plants is linked to the popular sector when learned within the family[45] and to the folk sector when recommended by traditional healers or prayer healers.[17] Similarly, spiritual practices, prayers, bathing practices, and *garrafadas* coexist with consultations, tests, chemotherapy, radiation therapy, surgery, and multidisciplinary follow-up, showing that professional care does not eliminate other forms of coping but coexists with them in women's lived experience, which calls for listening, dialogue, and cultural sensitivity within the professional sector.[8] Understanding this intersection makes it possible to recognize that cancer care for women is shaped by the interplay of biomedical, family, traditional, and spiritual knowledge.

Conclusion

This integrative review showed that women with cancer use different care practices throughout the course of illness and treatment, involving the professional, popular, and folk sectors. Although the professional sector predominated, particularly through biomedical treatments, consultations, tests, therapeutic procedures, and physical therapy follow-up, practices associated with the popular and folk sectors were also identified, including spirituality, self-care, family support, diet, medicinal plants, herbal teas, *garrafadas*, and advice from traditional healers or prayer healers. These findings show that coping with cancer is not limited to clinical treatment, as it involves emotional, family, spiritual, cultural, and social dimensions that influence women's choices, the meanings they attribute to illness, and the forms of care they use. In this multidisciplinary context, nursing plays a key role in recognizing these different forms of care and promoting comprehensive, humanized, safe, and culturally sensitive care that takes each woman's life context into account. The limited sociodemographic information in the included studies, particularly regarding race/skin color, restricted more in-depth analyses of inequalities in women's experience of cancer, while the lower visibility of practices in the folk sector points to the need for further research on traditional knowledge and its relationship with health care.
This study therefore contributes to a broader understanding of the different health care sectors accessed by women with cancer, showing that these practices do not occur in isolation but may occur concurrently, complement one another, or be used over time throughout treatment. Future research should therefore further investigate the intersections among the professional, popular, and folk sectors, considering the sociocultural contexts in which care trajectories unfold and that influence care practices in women's experience of cancer.

Study limitations

One limitation of this study was that most of the titles initially identified using the subject heading "cancer" concerned disease prevention rather than diagnosis, treatment, or care practices used by women during their experience of cancer. This reflects a limitation of the subject heading itself, since the term "cancer" does not, by itself, delimit the context of diagnosis and treatment and also retrieves studies focused on prevention. Another limitation was the use of COREQ as a guide for assessing the quality of the articles, because many articles were excluded for not reporting at least 70% of the required information. Relevant sociodemographic information was also limited in several included studies, particularly information on women's race/skin color and age, as shown in the sample characteristics. These limitations do not compromise the findings but reveal gaps in the literature and indicate the need for further research to expand knowledge of the different health care sectors in women's experience of cancer.

Authorship and contributions

AFF: Study conception and design; Data collection; Data analysis and interpretation; Drafting the manuscript; Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.
SGO: Study conception and design; Data collection; Data analysis and interpretation; Drafting the manuscript; Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.
FEM: Study conception and design; Data collection; Data analysis and interpretation; Drafting the manuscript; Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.
KSP: Data collection; Analysis and interpretation of data; Drafting of the manuscript; Critical review of the manuscript; Approval of the final version of the manuscript and acceptance of responsibility for it.

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AFJ: Data collection; Analysis and interpretation of data; Drafting of the manuscript; Critical review of the manuscript; Approval of the final version of the manuscript and acceptance of responsibility for it.

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Data availability statement
Because this is an integrative literature review, the study did not generate a primary dataset; therefore, the provision of additional data is not applicable.

Supplementary Material
- Reviewer A's Comments
- Reviewer B's comments
- Reply Letter to Reviewers

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