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“We always heal like this”: Illness management and identity expression in Latin American migrants in Spain

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ORIGINAL ARTICLE

"We always heal like this": Illness management and identity expression in Latin American migrants in Spain

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Abstract

The following article seeks to explore and analyze the use of lay and traditional medicines among Latin migrants in Spain, and the way in which these forms of treatment are accompanied by identity discourses and collective representations. The narratives and descriptions presented in this text are the result of ethnographic research on transnational health/illness/care processes, therapeutic itineraries and the overseas reproduction of folk practices from Latin America. In a pluralistic scenario loaded with barriers and structural difficulties, actions of self-care and home-based remedies facilitate problem solving, but also seem to act as a form of affiliation, resistance, negotiation of marginalized identities and an adjustment to people's new social space.

KEYWORDS
identity, Latin American, lay medicine, self-care, traditional medicines

INTRODUCTION

Transnational resettling experiences—with their historical, political, and social particularities—leave a significant biographical imprint on the people who go through them, affecting their interpersonal relations, cultural practices, and visions of themselves. Migrant bodies, a territory often understated in the geographies of mobility (Dunn, 2010), are the domains where custom, communion, foreignness, alienation, and disciplinary power converge, exposing both the conflicts and the versatility that unfold behind displacement. In the sphere of international migration, common occurrences like illness, injury, and affliction represent disruptive events that interfere and alter people's daily existence and the sustainability of their migratory project. Their effect is cumulative: the physical/emotional burden of infirmity adds to the personal impact of relocation.

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However, illness cannot be reduced solely to a force of disturbance. Besides risks and challenges, it can also reveal the ways in which individuals and communities reinterpret adversity, mobilize resources, and develop strategies to endure and respond to difficult circumstances (Gentil, 2009). Hardship may be accompanied by different forms of applied knowledge, relational practices, and modes of meaning-making that positively engage other dimensions of human experience besides the medical ones (Kong and Hsieh, 2011). In this context, the actions undertaken to address health issues not only reflect the possibilities and constraints within diverse care systems but also the protective skills and coping strategies that groups are capable of exercising to ensure their well-being.

For some populations, such as migrant ones, the symbolic elements associated with certain healthcare practices can stimulate cultural claims and new understandings of belonging. From this perspective, narratives surrounding adversity—illness or loss of well-being—may be laden with representations about group affiliation and mutual qualities to support or negotiate positions within the social order. For instance, therapeutic systems or traditions can be associated with ethnic or national identities; and feelings of pride or commitment to some forms of medicine can be a type of cultural politics linked to identification and distinction from others (Reynolds Whyte, 2009). Additionally, healing activities that operate in pluralistic contexts can be grounded on identity-based motivations and ideological-symbolic principles beyond the merely pragmatic (Oyserman et al. 2014).

Focusing on the health-seeking activities of Latin American migrants in Spain, this article explores how lay, traditional, and self-managed care shape the embodied experience of illness and the production of migrant subjectivities. By situating these practices within the local and transnational contexts, the study examines how people navigate between professionalized systems and home-based or community-driven forms of treatment, and how their therapeutic decisions are informed by, and actively contribute to, shifting notions of self, belonging, and collective identity. Drawing on ethnographic fieldwork and informed by a critical approach, the research highlights how migrants' health choices not only act as pragmatic responses to illness and structural marginalization, but as meaningful forms of agency through which they reinterpret their circumstances, sustain cultural attachments, and generate new forms of relationality.

This work draws on constructionist approaches to identity, conceiving it as a mutable phenomenon shaped by social, political, cultural, and economic contexts. According to Hall (1994), identity is understood not as a manifestation of fixed or pre-existing essences, but as a constant production constituted through acts of representation and relational positioning. Despite ongoing debates surrounding the use of identity as an analytical category, Pratt Erwig's (2004) observation that identities are empirically present in public culture and in people's discourses remains compelling, describing them as "reified symbols and markers of social position and cultural difference that are embodied in individuals" (p. 118). The present study focuses, therefore, on the processes of identification—namely, the psychological, symbolic, and pragmatic mechanisms through which identity becomes concretized (Sifuentes-Jauregui, 2006).

Given the intimate ties between identification, bodily experience, and collective association, healing practices and popular medical manifestations constitute a productive site for examining how these dynamics materialize. The concept of *health identities* (Fox & Ward, 2008) is particularly pertinent in this context, as it links action, practice, and embodiment to the formation of subjectivities. Conceived as a dynamic, creative process situated within specific social settings, this notion captures the different ways individuals or groups orient themselves in relation to health. Such positioning arise from the interaction between the cultural, material, and social capital available to people and the extent to which their choices and values depend on internal or external forms of validation. In this sense, health—along with other dimensions of bodily experience—constitutes a crucial element in the development of certain identities, as it entails the mobilization of diverse resources (technologies, knowledge, specialists) based on belief systems, norms, and principles, both institutional and personal. Among the migrant population, healthcare measures comprise a mixed set of options and knowledge from the host society, transnational networks, and pre-displacement environments (Muniz de Medeiros et al., 2012; González-Vázquez et al., 2016). For this reason, their chosen therapeutic practices become an

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opportunity to affirm their identities of origin, renegotiate new forms of belonging, or construct a sense of self linked to diaspora.

METHODS

This article is based on a larger ethnographic study on the therapeutic itineraries[1] of Latin Americans in Spain, which sought to explore the personal and communal narratives around migration, illness, and health-seeking. Fieldwork took place between 2016 and 2021 in the city of Salamanca, combining semi-structured interviews with community members, observation in social and institutional spaces, and auto-ethnographic reflections based on my own experience as a *Latina* migrant at the time.

My interlocutors were women and men, 20 to 75 years old, with diverse backgrounds and demographic characteristics (see Table 1). The group included irregular immigrants, permanent residents, naturalized citizens, asylum seekers, and refugees, as well as students and their companions. Most of them had university or secondary education, reflecting a relatively high educational capital. However, their integration into the labor market was heterogeneous: one-third were unemployed, while others worked in the domestic/care sector, retail and catering industries. This reflects a group with high levels of qualification but with fragmented and, in many cases, precarious employment and migratory trajectories.

Participants' recruitment was made either by direct contact in communal spaces across the city or snowballing. Interviewees were selected randomly, with the only predetermined criterion of at least one year of settlement in Spain. The interviews were conducted in Spanish, in locations selected by the informants. A semi-structured interview guide was used in all cases, with open-ended questions about health experiences, decisions, and practices before and after migration.

People's accounts were supplemented with observation in neighborhood associations, NGOs for the migrant population, and *locutorios*—shops offering communications services, international remittances, and the sale of imported products from Latin America. This allowed me to witness and register numerous medicinal recipes and practices, interactions, and informal conversations on health and displacement. The study also incorporated autoethnographic records in which I documented my own episodes of illness, treatment pathways, and the strategies used to navigate them. Being an Argentinian woman living in Spain allowed me to experience some of the complexities of migration and healthcare firsthand while fostering a fluid rapport with informants, who often drew on our shared condition as Latin American migrants to relate and articulate their own situations. Their narratives at times echoed my fears, conflicts, and practices, while also revealing important contrasts and new insights. Incorporating first-person accounts demanded sustained reflexivity, given the risks of conflating my experiences with those of participants or losing analytical distance (Anderson, 2006). To address this, I systematically compared personal notes with interview material and ethnographic observations, which helped maintain interpretive rigor and clarify the boundaries between my trajectory and theirs. I also remained attentive to biographical, generational, gender, ethnic, and class differences, ensuring my own path did not become a reference point for interpreting their distinct migration and health circumstances.

Interview transcripts and field notes were analyzed thematically using ATLAS.ti software (version 8.4.24, 2020). The software was employed to organize, inductively code, and retrieve segments of text, enabling systematic comparison across interviews, field observations, and notes. The participant quotes included in this text were translated by the author, and all names presented next to them are pseudonyms.

On identifications and terminology

Throughout this article, the term *Latin Americans* is used to refer collectively to the selected study group. This requires a series of reflections and clarifications on the decision to use identifiers that may at first seem generalizing or monolithic.

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TABLE 1 Participant demographics

	Name	Origin	Gender	Age	Immigration status	Education level	Occupation	Health coverage
1	Alfonsina	Mexico	F	70	I	S	Pensioner	Private
2	Catalina	Mexico	F	40	N	U	Unemployed	Private
3	César	Honduras	M	43	AS	None	Unemployed	Public
4	Telma	Honduras	F	40	AS	P	Cook	Public
5	Gloria	Honduras	F	45	AS	P	Pensioner (Dis)	Public
6	Luisa	Bolivia	F	30	SV	U	Student	Private
7	Felicia	Bolivia	F	40	PR	S	Housemaid	Public
8	Rafael	Bolivia	M	42	PR	TT	Factory worker	Public
9	Eva	Venezuela	F	50	AS	U	Unemployed	Public
10	Francisco	Uruguay	M	48	N	S	Hairdresser	Public
11	Eloísa	Colombia	F	40	I	U	Unemployed	None*
12	Roberta	Brazil	F	31	PR	U	Producer	Private
13	Juana	Bolivia	F	29	PR	U	Unemployed	Public
14	José	Dominican Republic	M	31	SV	U	Student	Private
15	Eugenio	Mexico	M	31	SV	U	Student	Private
16	Valentina	Honduras	F	50	I	P	Carer	None*
17	Alejandra	Venezuela	F	50	I	U	Carer	Private
18	Hugo	Costa Rica	M	39	SS	U	Unemployed	Private
19	Lucio	Guatemala	M	43	PR	U	Shopkeeper	Public
20	Alicia	Guatemala	F	41	PR	S	Shopkeeper	Public
21	Melvin	Brazil	M	42	SV	U	Freelancer	Private
22	Bruno	Colombia	M	28	I	S	Unemployed	None*
23	Antonio	Puerto Rico	M	29	SV	U	Student	Private
24	Ángela	Costa Rica	F	41	SV	U	Student	Private
25	Julia	Dominican Republic	F	26	SV	U	Student	Private
26	Pablo	Dominican Republic	M	38	PR	U	Teacher	Public
27	Úrsula	Guatemala	F	33	PR	S	Unemployed	Public
28	Jorge	Ecuador	M	30	SV	U	Student	Private
29	Judith	Venezuela	F	42	AS	S	Unemployed	Public
30	Isabel	Honduras	F	41	R	P	Carer	Public
31	Gustavo	Venezuela	M	45	R	S	Unemployed	Public
32	Lydia	Honduras	F	35	R	TT	Unemployed	Public
33	Carla	Venezuela	F	31	SV	U	Student	Private
34	María	Peru	F	55	PR	S	Housemaid	Public
35	Eugenia	Peru	F	40	I	S	Carer	None*
36	Francisca	Mexico	F	40	PR	U	Housemaid	Public
37	Esther	Dominican Republic	F	47	PR	S	Housemaid	Public
38	Laura	Dominican Republic	F	35	PR	S	Unemployed	Public
39	Irene	Venezuela	F	30	PR	U	Shopkeeper	Public

(Continues)

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TABLE 1 (Continued)

	Name	Origin	Gender	Age	Immigration status	Education level	Occupation	Health coverage
40	Valeria	Venezuela	F	33	PR	U	Shopkeeper	Public
41	Guadalupe	Venezuela	F	60	I	S	Unemployed	None*
42	Greta	Chile	F	34	SV	U	Unemployed	Private
43	Rita	Honduras	F	39	I	S	Unemployed	None*
44	Cecilia	Colombia	F	68	N	TT	Pensioner	Public
45	Flavia	Brazil	F	30	I	U	Carer	Private
46	Miguel	Brazil	M	29	I	TT	Unemployed	Private
47	Aníbal	Argentina	M	40	N	S	Artist	Public
48	Sara	Argentina	F	38	N	U	Carer	Public
49	Trinidad	Argentina	F	36	SV	U	Student	Private
50	Lara	El Salvador	F	36	I	U	Unemployed	Private

Immigration status: AS (Asylum seeker) I (Irregular),N (Naturalized), PR (Permanent Residency), R (Refugee), SS (Student-Spouse Visa), SV (Student Visa).
Educational level: P (Primary), S (Secondary), TT (Technical training), U (University)
*No health coverage at the time of the interview (pre-universalization of 2018)

There is no doubt that Latin America is characterized by cultural, ethnic and racial diversity, and that its migrant populations naturally reflect this heterogeneity. In certain contexts, the uncritical use of umbrella classifications and broad identity labels can obscure internal differences and particularities, simplifying or totalizing people's experiences under a few terms (Diaz McConnell & Delgado-Romero, 2004). In other cases, however, the use of pan-ethnic categories can be part of purposeful strategies of reappropriation/self-recognition, that actively arise from social actors themselves (Espiritu, 2019; Martínez & Gonzalez, 2021).

During the course of this study, informants frequently used the expression "we Latinos/Latin Americans" to refer to themselves and their practices. Such identification did not seem to conflict or replace other identities (e.g. national), but rather add to them, expanding their grouping capacity and emphasizing collective experiences. As a situated phenomenon in the context of migration, pan-ethnicity can become a political and cultural project of diaspora, that uphold and revitalizes a wide range of cultural expressions (Cuberos Gallardo, 2014). At the same time, it can also be shaped by instrumental rationalities, seeking to mobilize larger solidarity and support networks than those provided by other categories (Liberona & Pagnotta, 2012). As Mallet-Garcia and Garcia (2025) point out, the assertive reinforcement of regional identities (e.g. Latin American) might multiply the resources and opportunities in contexts of precarity. It can also contribute to socialization and commonality, through the manifestation of shared elements and similar experiences, values and practices (Echeverri Buriticá, 2012).

Given that this research explores the intersection between healthcare practices and identity (re)construction, it seems pertinent to present and explore the relevant identification terms that emerge in the field. While recognizing the limitations and scholarly critiques of pan-ethnic classification, this work employs the category *Latin American* not as a thoughtless act of erasure, but as an anthropological resource to recover and respect the emic categories used by the participants.

THERAPEUTIC PLURALISM AND THE CHOICE OF CARE

Analyzing the health/disease/care processes of Latin Americans settled in Spain requires some understanding of the therapeutic options that unfold in urban settings like the one under study. The city of Salamanca counts with a fairly wide range of curative services, supplied by various models, spaces,

and types of practitioners. The commodification of healthcare, the increasing reach of digital communication technologies, and the development of global retail infrastructures have all contributed to an increased medical heterogeneity, even in small locations (Krause et al., 2012; Penkala-Gawęcka & Rajtar, 2016). Despite this diversity, the presence of multiple treatment alternatives does not translate into an all-encompassing, let alone even, utilization of them. The public's relationship with different curative approaches is shaped by complex patterns of engagement, constraint, and intentional decision-making, all embedded within broader social and political contexts that alternate between openness/equality and exclusion/restriction. In the face of *what is available* appears *what is useful*, but most importantly, *what is possible* and *what is preferable* (Menéndez, 2003; Gideon 2011).

Drawing on the classification proposed by Kleinman (1978), this section reviews the participants' experiences with the different components of the local medical landscape, illustrating their accounted patterns of use and laying the groundwork for a discussion on the overlap between health management and identity-building processes. It will begin by exploring people's interactions with the professional sector (biomedical)[2], followed by lay practices of self-care and the use of folk medicines, both prominent features in the narratives collected.

Institutional and professional healthcare

Spain's biomedical healthcare provision is based on the National Health System (SNS)—a tax-funded Beveridge-type model that covers over 95% of the population (Ministerio de Sanidad, 2025), and a complementary private sector, represented by insurance-based clinics, practices, and other industries.

Public medicine is organized territorially by autonomous communities (administrative divisions), who manage local hospitals, primary care centers and specialized services. Since 2018, the SNS has restored universal coverage based on residence in an attempt to reinforce equity and service scope across multiple groups. According to the Royal Decree-law 7/2018 (España, Jefatura del Estado, 2018), foreigners who have remained in the country for more than 90 days—regardless of their migratory status—have the right of use of public institutional care in similar conditions as the Spanish nationals. However, the bureaucratic requirements for such allowance vary across the different autonomous communities and, together with other barriers—like difficult access to information, irregular migrants' fear of prosecution and delays in registration—still leave great portions of the migrant population at risk of healthcare exclusion (Padilla, 2021; Yo Sí Sanidad Universal, 2022; Médicos del Mundo, 2024).

The ethnographic research conducted for this study showed that some informants—those in irregular situation or with precarious employment—found biomedical care unattainable, left only for severe and urgent incidents. More striking, however, were the accounts of the majority of Latin Americans who, despite having formal access to professional aid and having lived in Spain for multiple years, expressed a reluctance to use these services. Even when legally entitled to SNS provision or covered by private insurance, many conveyed the belief that consulting a physician was not the preferred way to address health issues and that biomedical intervention should generally be avoided.

Various circumstances—like bureaucratization of healthcare provision, fear of discrimination, and differences in the way medical treatment is culturally conceptualized—can make the visit to the biomedical professional a particularly undesirable situation for some migrants (Lamarque & Moro, 2018). During interviews, several people alleged that appointments with Spanish professionals did not represent a pleasant and comfortable space, feeling a lack of concern for patient's distress and little emotional support. Others expressed suspicion and fear about referrals, worried that an initial consultation could lead to more complex diagnoses than expected or reveal additional, previously unknown conditions:

> "I could only go [to the doctor] if I think recovery is taking too long, or if I feel I am in trouble. In those cases, and sort of as a last resort, I end up going" [Trinidad, 36, Argentina]

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> "The problem with doctors is that you enter for one thing and leave with another." [Eugenia, 40, Peru]

For some, the distant attitude of certain doctors has led to distrust in their professional judgment and their ability to solve problems. Their interactions, repeatedly referred to as detached, or even "cold," did not correspond with the common ideal of a careful physician who listens to patients and performs thorough examinations (Torres Vaca et al., 2013). Instead, Latin patients identified a reduction in the tactile component of clinical assessments (compared to their home country experiences)—expressed by "not being touched" (Hyman, 2020)—leaving many consultations feeling incomplete and wasteful of their time. This coincides with what Lupton and Maslen (2017) have noted about the affective and emotional value of hands-on medical checkups, which has a primary influence on healing processes and treatment compliance.

> "Here, the treatment is a bit colder, like less humane. In Venezuela they [doctors] treat you more affectionately. Yes… At least where I come from it's like that. They ask how you are…. That's not always the case here" [Irene, 30, Venezuela]

> "It's different here. You feel like there is no trust with the doctor. If you go, they treat you, but you feel that. In Venezuela when you go to the doctor you feel like you went to the doctor" [Valeria, 33, Venezuela]

As highlighted by Dixon-Woods et al. (2005), cultural dissonance between the norms and values of organizations and those of their users can shape patients' patterns of use and engagement, while minoritized groups from various backgrounds may become alienated from institutions that appear to stereotype them or treat them without sensitivity. These strained dynamics with medical professionals unfold in a wider social context in which growing discourses of nationalism, bigotry, and xenophobia increasingly permeate the experiences of foreigners in Spain (Pérez Joya & Lozano Martín, 2021). Such tensions surfaced in the accounts of several informants, including Alicia, who—like others—perceived a differential treatment of migrants in healthcare, especially in doctor-patient exchanges:

> "There's a difference… if you're Spanish or foreign. How are they going to treat you the same? Of course, it's not in every case, there are some wonderful doctors. But others… You notice it when you go, as soon as you enter the practice" [Alicia, 41, Guatemala]

This coincides with previous research, where users of the SNS reported significant percentages of nationality-based discrimination (Velasco et al., 2016).

In view of this, the inhospitable circumstances of the migratory context seem to drive many subjects to develop defensive behaviors in an attempt to protect themselves from possible negative situations that could worsen their processes of settlement. The nature of the encounter with medical professionals often mirrors the experiences with other areas of public administration (e.g., immigration authorities), where power imbalances between actors can strip foreign individuals of their autonomy and leave them at the mercy of external dispositions. This fraught relationship with health institutions means that, in many cases, individuals choose non-institutional strategies to manage their health, despite having formal access to biomedical services. In this context—and notwithstanding the evident structural inequalities affecting migrant groups—the avoidance of professional care can function as an act of separation, through which people reclaim a sense of control over their bodies and life processes.

Lay and traditional medicine

The difficulties and limitations associated with professional healthcare—combined with pragmatic aspects and personal preferences—positioned self-care (lay) strategies as a central component in

participants' therapeutic itineraries. This sphere is based on a transactional and syncretic interaction between widespread informal knowledge and elements from different medical models, picked in function of the relevant needs (Baer, 2022). Even knowledge that appears to be incompatible or antagonistic from a paradigmatic point of view is actively articulated by those applying it, with the sole objective of alleviating their suffering and providing answers to their problems (Hernández Tezoquipa et al., 2001; Belliard & Ramírez-Johnson, 2005).

Self-medication with over-the-counter or previously prescribed pharmaceuticals, the consumption of imported medicinal goods, and the preparation of home remedies were among the most frequently reported practices, regardless of subjects' age, origin, and migratory status. Within these strategies, domestic medicine held a particularly prominent space, since it was acknowledged in all the interviews and was often accompanied by identity-focused discourses, supporting and reconfiguring people's experiences of illness and migration.

> "Well, the first thing you do [when ill] is look for a plant. One of those that you are accustomed to using for any ache… Then you make tea, and you get better" [Gloria, 45, Honduras]

> "We drink juices and herbs. If they tell you a plant is good for a headache… We try to do that" [Flavia, 30, Brazil]

> "I always use medicinal plants because that is how we do it in Mexico. I usually reach into whatever I have in the cupboard to make my own syrup. My mother taught me these things, and I still do them today" [Francisca, 40, Mexico]

The use of herbal medicine and homemade recipes was mentioned for treating numerous conditions of diverse etiology and severity, both in adults and children. This included a broad range of local and foreign plants, obtained through different means. Most of these ingredients are commonly available within households, so their supply is simple and direct through nearby retailers and markets. Others, especially those exclusive to Latin America, are usually ordered from specialized stores (herbalist's, organic shops, markets and *locutorios*) or distributed by other migrants or sporadic visitors:

> "Noni [*Morinda Citrifolia*]. I still use it; I find it in the herbalist shop. You can make an extract from the fruit and drink that. It stimulates your immune system. It also balances the pH in your stomach, preventing heartburn. It is very effective" [Lucio, 43, Guatemala]

> "In the locutorios you see a lot of Bolivian people. I think that there is one owned by a Guatemalan. I don't know if that one sells medicinal stuff, but definitely the Bolivians do. They always have these sorts of things" [Rita, 39, Honduras]

In many cases, the preference for these therapeutic actions was based on a greater acceptance of *natural* components over the *chemical* or *artificial* ones attributed to pharmaceutical drugs (Waldstein, 2006). This also relates to certain beliefs about the origin or cause of illnesses, for example, those produced by an excess of heat or cold in the body. Thus, *cold* ingredients (e.g., mint, peppermint, pennyroyal, aloe vera) are needed to treat *hot* problems like gastritis, abscesses, kidney and liver infections; and *hot* plants (e.g., ginger, lemongrass, rue, cinnamon) are used for *cold* conditions such as respiratory infections, menstrual and muscular pain[3].

> "When you have the flu, your chest is cold. So, what you need to do is to take something hot. Lemongrass is like that. It's a bush. What it does is reheat a chest that has gotten cold due to illness. It brings back warmth" [Rita, 39, Honduras]

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On a few occasions—particularly among participants from Central America, Bolivia and Argentina—community-managed treatments also incorporated practices from Andean and Mesoamerican medical traditions, usually performed by informally recognized experts across the transnational space. Although less common than botanical remedies, these actions were referred to treat folk illnesses such as *susto*, *empacho*, *ojo* (evil eye) or *caída de mollera*[4], which are all believed to be outside the scope of biomedicine (Andrews et al., 2013). Informants reported consulting several knowledgeable practitioners—often family members or neighbors—located both in Salamanca and abroad (and therefore, offering guidance or healing from a distance). Unlike other established migrant communities—such as those in the US, where healers are classified into distinct categories (e.g., *curanderos*, *sobadores*, and *hueseros*) (Cruz et al., 2022)—none of the practitioners in the study was identified with a special title, nor were their activities framed as a form of occupation. However, their healing skills were valued among the interlocutors, based on trust and past efficacy.

> "*Empacho* is common. It's very easy to treat. They rub the person with oil and other ingredients, and they detach what was stuck to the intestine. Mi wife has done it to my children here, rubbing them with hot oil to cure their *empacho*" [Lucio, 43, Guatemala]

> "My sister Betty, who came here with me, used to cure my daughters from *ojo* when they were little. She knows a lot about that. [Laughing] She's the 'witch' aunt. I am relieved to have her with me, in case something like that happens again" [Laura, 35, Dominican Republic]

Both herbal cures and traditional practices were discursively supported by appealing to customs, history and the endorsement of previous generations. Much of this knowledge was acquired in people's countries of origin, typically within the family and in response to frequent ailments.

> "It is our heritage, the best thing our mothers and grandmothers could have left us. The wisdom of traditional medicine. We still use it today, so you can't say it's not good" [Isabel, 41, Honduras]

> "I remember that my family has always known about these remedies. Grandparents, aunts. So, we have not had to resort to other people. Always among ourselves" [Eugenia, 40, Peru]

> "We learned those recipes in our country; they are things from long ago. We all cured ourselves that way and here we are. It must have value, right?" [Ursula, 33, Guatemala]

Its value as a cultural heritage was frequently emphasized, alongside its accessibility in comparison to other options that were perceived as problematic, challenging or unreliable. These findings align with previous research on Latin migration in other countries like the US (Belliard & Ramírez-Johnson, 2005; Andrews et al., 2015), the UK (Ceuterick & Vandebroek, 2017) and Sweden (Hjelm & Bard, 2013).

Lastly, lay medicine was mentioned as an immediate community response to persistent inequalities in accessing the Spanish health system, especially for those that were undocumented. Prior to the legislative change of 2018, irregular migrants relied almost exclusively on self-care to resolve or alleviate illnesses. The fear of having to pay large sums of money or being reported to the authorities made institutional treatment unfeasible, with the exception of emergencies and pediatric/neonatal services.

> "As soon as I arrived, I had a very bad rash. I was pouring rosemary alcohol on my skin and thinking positively to make it go away. I didn't go to the hospital for fear that they wouldn't treat me, that they would charge me a lot of money or call the police. I was undocumented, imagine that. So, I did what I knew and hoped it would work" [Eugenia, 40, Peru].

For some, this was paired with occupational and logistical difficulties (absence of sick leave for workers in submerged economy or additional travel expenses) that complicated visits to the doctor and limited the course of action. In all these cases, the generation of spontaneous support networks and the circulation of medical advice within the Latin community were some of the deployed resources to mitigate distress.

In addition to convenience and effectiveness, self-administered health actions have been shown to satisfy physical, emotional, spiritual and relational needs in a context that regularly severs those aspects (Lamarque & Moro Gutiérrez, 2021). Allowing flexibility and knowledge exchange, lay practices are then valued for granting people with greater agency and the capacity to intervene in their own bodies (Guell, 2012). In this way—and as Ceuterick and Vandebroek (2017) identified in Andean communities in the United Kingdom—the choice of these therapies responds to diverse repertoires, ranging from the exaltation of self-sufficiency, adaptive strategies in the face of an unsatisfactory biomedical system, consumption preferences based on health beliefs, and custom-oriented inclinations.

CURING ONESELF, BEING ONESELF

The experiences gathered in this work show the way in which everyday practices and therapeutic actions of Latin migrants actively contribute to the construction of what Dick and Dossa (2007) describe as "healthy spaces," that is, geographical, social, and symbolic environments where people's agency becomes present. The health decisions made in the transnational context were often accompanied by discourses of identity, which invoked a shared moral and collective affiliation among participants. Beyond the practical advantages of self-managed care, domestic and folk medicines were used to reaffirm national and pan-ethnic identifications of those who employed them, precisely in an environment where these identities can often be an object of discredit and struggle. As many authors have stated, the maintenance of cultural elements perceived as their own by minoritized communities can function as a form of self-representation (Press, 1978), enabling them to negotiate and reshape power dynamics (Gold & Clapp, 2011; Kong & Hsieh, 2012).

For some participants—particularly the elderly or the ones that migrated a long time ago—the continued use of home-based remedies worked as proof of authenticity, demonstrating that they "are still Latinos" and possess core values like self-reliance, strength of character, and solidarity:

> "No matter where we go, we always heal like this. It's tradition" [Judith, 42, Venezuela]
>
> "In our veins we carry that culture of curing ourselves with what nature provides. And we learn this and teach it to our children, so it passes from one generation to the next" [Esther, 47, Dominican Republic]

In this sense, lay and traditional practices were linked to a *way of doing* and, more significantly, a *way of being* that was deemed protective. The idea of holding certain positive attributes as an inherent part of their culture (a national, regional, or pan-ethnic ethos) could ease the adaptation of migrant groups to the new social environment by putting the focus on their own capacities for resilience and cooperation (Gentil, 2009; Hernández Pulgarín, 2016). Healing oneself, having the knowledge for it, and being able to pass it onto others is a skill that offers certainty among doubt, and provides a new meaning to everyday occurrences. Such narratives of self and health have, therefore, a performative effect in the sense described by Austin (1975), producing a visible influence over people's feelings, actions, and thoughts. The symbolic power behind those discourses ends up creating realities and supporting a social place against external frontiers and liminality (Bourdieu, 1998; Butler 2006). As Ceuterick and Vandebroek (2017: 3) point out, "when seeking healthcare, people produce and reproduce narratives that act as metaphors for their position in the social world." Stating that one belongs to a specific group and therefore retains certain cultural resources helps to counteract possible feelings of uprootedness and alienation, especially in vulnerable times such as episodes of illness or disease.

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In relation to the processes of identity (re)construction, the use of lay and traditional forms of care also became a demarcating element, that is, a basis for drawing a distinction between a self-proclaimed "us" and an external "them." This was irrespective of other characteristics, like status, age or class. Across interviews, the tales of therapeutic actions were mostly performed by a plural subject, an undetermined "we" that seemed to represent a social self and a shared experience. When asked about this (*who's we?*), interlocutors would refer to their fellow nationals or the totality of Latinos, especially migrant ones. In any case, this characterization was regularly used to deliberately separate themselves from the locals, especially when talking about behaviors and approaches to health/illness.

> "We come from countries where the health systems don't work, they are not organized… So, you must find a way to help yourself, your family, and your neighbors. We are resourceful" [Alfonsina, 70, Mexico]

> "I like having learned these things and helping others. That's how we are, the Latinos. It's good that people here get the chance to see it" [Isabel, 41, Honduras]

> "Here, I feel that [Spanish] people go to the doctor for everything. And they always ask for prescriptions. We, on the other hand, don't keep stuff like that at home, don't ask for any, because we know it's not good for us… We buy a box of aspirins, and we save it for emergencies, that's it. The rest, we do on our own" [Alicia, 41, Guatemala]

By articulating *difference* in their own terms, participants challenged the established order of the migratory space, in which alienating discourses are routinely directed at them through multiple social and institutional channels, including government, media, and local populations. As Reynolds Whyte (2009) argues, the assertion of what was previously devalued represents yet another example of identity politics in the realm of health, where people negotiate visibility and recognition based on their sense of self. At the same time, this enunciated *we* functions as a unifying force, bringing together different nationalities, backgrounds, and life experiences into a shared category ("We, the Latinos") that co-exists with other identifications without conflict (Cuberos Gallardo, 2014). According to Hall (1994), cultural identity is constructed in a dialogic relationship between an axis of continuity/similarity and one of difference/rupture. In this way, people who are inherently diverse—by belonging to various countries, ages, genders, and social classes—assemble and recognize themselves by being migrants and sharing a way of understanding and caring for their health.

These experiences of identification and demarcation were also evident during accounts of social conflict, in which differences in health identities and practices were cited as an example of the complex relationship with the local population. The testimony of Felicia, who settled in Salamanca more than fifteen years ago, illustrates the kind of problematic interactions that often occurred with Spanish people in relation to Latin home remedies and lay healthcare:

> "Once, I was at the association and was giving some health advice to a Moroccan woman. Her daughter had a terrible cold, highly congested… I told her I could give her some *Mentisan*[5] to rub on her chest, back, and keep her well wrapped. It loosens the phlegm. But then Carmen [*Spanish social worker and NGO director*] heard me, and she almost had a fit. She told me off for giving the woman advice, and said that those herbs could hurt the child… And I didn't like that, because I would never recommend something that I know is harmful. The fact that they [*Spaniards*] don't trust our culture or the way we can cure ourselves… Why does she think anything is going to happen? This product is made from well-known plants and is like *Vick's VapoRub*… Carmen told the Moroccan woman she should only take the girl to the doctor, and she had already taken her, with no results. The Spanish don't trust anything but their own stuff" [Felicia, 40, Bolivia]

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Besides expressing distress about judgement and rejection, most of the time the participants used these opportunities to continue exalting their cultural identification and a constructed sense of resilient self. These stories also exemplified the spontaneous spaces of knowledge exchange with other migrants from different regions and cultures who, as "fellow outsiders," were presumed to be receptive to non-hegemonic medical practices. As Subramani (2024) notes, displaced people can therefore experience a sense of belonging through relationships and caring connections with others who are deemed similar, in spite of contexts of perceived degradation.

> "Sometimes you mention something traditional to the doctor, and they say: '*Don't tell me about that*'. There is a rejection of our empirical knowledge of home medicine… But if we don't strengthen this knowledge —which has provided answers, it is valuable and has allowed many families to survive— then what? Many of us have not had any access to a doctor and yet, we have cured ourselves. We know. And here they make you feel like you are an alien. It is important that people don't get discouraged, that they continue to turn to those things that are close to them, like nature" [Rafael, 42, Bolivia].

Consequently, some participants claimed the responsibility to continue with these customs as a form of contestation, based on feelings of cultural pride and a need for resistance. Furthermore, by recognizing themselves as bearers of valuable knowledge, people were able to assume a role of expertise that also counteracts their experiences of marginalization in the healthcare system (Guell, 2012). This reflects those identity positions described by Fox and Ward (2008), in which, despite having limited resources, people apply internal validation strategies to support their practices, opting for self-administered treatments and reducing their use of institutional health services. Additionally, this shows that identification with a minoritized group can act as a buffer against exclusion but also can become an actively mobilized resource to combat environmental threats and promote wellbeing (Jetten et al., 2011).

CONCLUSION

Despite the processes of change following migration to Spain, lay and traditional medical knowledge have proven to constitute a highly valued collective capital for Latin Americans, backed by its accessibility, heritage, and perceived efficacy. Apart from their practical benefits, the presence of these actions plays a role in the national/pan-ethnic reaffirmation and cultural pride of those engaged with them, precisely in a setting that puts foreign identities under dispute. For minoritized communities such as migrants, the preservation of their own cultural elements (linguistic, artistic, religious, culinary, and, in this case, medical) reinforces their capacity for counter-hegemonic action, favoring the negotiation of power and agency in certain matters like their own bodies. Additionally, the employment of community-based treatments was linked to highly praised values such as self-sufficiency, competence, and resistance, which gain an even larger significance in the transnational space. Hence, the sustained practice of home-based health care represents that "one is still Latino," and that those positive attributes that are associated with this evoked culture have a protective function to those who ascribe to it.

The persistence of inequalities in accessing institutional healthcare and the difficulties derived from the encounter with the local biomedical system were some of the reasons that led most Latin people to believe they ought to manage healthcare in their own hands and their own terms. Faced with structural limitations and a social scenario of increasing intolerance, this group rehearses and refines a myriad of responses to disease, all of them aimed at satisfying their immediate needs and sustaining the project that has brought them across the ocean. In other situations, the employment of self-care practices was more related to a conscious choice, driven by ideological positions about what healthcare should be and the proper way to handle physical and mental difficulties. The analysis of this community's trajectories of health/illness/care has provided insight into the symbolic and pragmatic manifestations of a resilient and interconnected group, which finds, through action and narrative, a way to redefine themselves

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and others. Among multiple cultural expressions, lay and traditional medicines were used to create a “unified” identity across diversity and to build bridges to those people and places that were (physically) left behind.

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ENDNOTES

[1] The series of actions and decisions implied in the resolution of illness (Sindzingre, 1985).

[2] Despite the increasing availability of Complementary and Alternative Medicines in the study context, very few interviewees identified them as preferred options for managing their health. A small number mentioned homeopathy and acupuncture, recalling past experiences “back home” and valuing their perceived curative potential. Yet the high costs of these services in Spain placed them largely out of reach, leading to sporadic and inconsistent use within the group.

[3] This forms part of the beliefs of many Latin American cultures (especially in Mesoamerica and the Andean region), which conceive health in terms of a natural balance between opposing forces/energies and certain qualities/components of the organism (Idoyaga Molina, 1999, Álvarez Quiroz et al., 2017).

[4] For detailed discussions on these ailments see: Rubel et al. (1991), Baer and Bustillo (2008) and Weller et al. (1993; 2015).

[5] Commercial ointment from Bolivia, made from botanical essential oils and used for colds, headaches, muscular issues and minor ailments.

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