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Therapeutic Itineraries and Processes of Illness Care in Latin American Migrants: Conflicts, Negotiations, and Adaptations

Itinerarios terapéuticos y procesos de atención de la enfermedad en migrantes latinoamericanos: conflictos, negociaciones y adaptaciones

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ABSTRACT

The following article explores the different health care strategies deployed in the context of Latin American immigration in Spain. Based on an ethnographic approach, the discourses of the actors involved are exposed and analyzed in order to reconstruct the main characteristics of their therapeutic itineraries and the factors involved in their conformation. In this scenario —characterized by medical pluralism—, self-care and -healing represents a preferential option, which not only facilitates the resolution of problems but also stands as a form of resistance, identity revaluation, negotiation and adaptation to their new social space.

Keywords: 1. therapeutic processes, 2. traditional medicine, 3. medical pluralism, 4. Spain, 5. Latin America.

RESUMEN

El siguiente artículo explora las distintas estrategias de atención de la enfermedad desplegadas en el contexto de la inmigración latinoamericana en España. A partir de una aproximación etnográfica, se exponen y analizan los discursos de los propios actores para reconstruir las principales características de sus trayectorias terapéuticas y los factores intervinientes en su conformación. En este escenario –caracterizado por el pluralismo médico–, las acciones de autoatención y cuidado representan una vía preferencial, que no sólo facilita la resolución de problemas sino que se erige como forma de resistencia, revalorización identitaria, negociación y adaptación al nuevo espacio social.

Palabras clave: 1. procesos terapéuticos, 2. medicina tradicional, 3. pluralismo médico, 4. España, 5. América Latina.

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INTRODUCTION

Getting sick, feeling pain or suffering some kind of illness, are universal and inevitable facts of human life; the way in which we think of, feel about and go through them, combines particular subjectivities altogether with our social and cultural framework of belonging, establishing for each event of discomfort a series of values, roles, representations, and expectations. Health conditions, as well as the social responses that arise to solve them, make up the health/disease/care process defined by Eduardo Menéndez (1994; 2002) within social anthropology.

Recovering health is a dynamic exercise that starts not only from the experience itself, but also from the scenario in which it is carried out (Sacchi, Hausberger, & Pereyra, 2007). As Augé (1986) points out, a disease is anchored to the reality of the body that suffers from it. In this sense, the contextual perspective provided by social sciences becomes of great relevance, since it allows analyzing the health/disease constructions developed and used by social groups in relation to the time and space they inhabit (Laurell 1986).

Taking this approach into account, it is of particular interest to research the conformation of the health/disease/care processes in a context as specific and particular as the migratory space. Because of their strong symbolic load, territorial displacements represent a before and after in the biography of those who go through them. Their undertaking involves changes in the way of life: social links, available resources, and vision regarding the future. Likewise, the disruptive nature of migration can lead to, in many cases, a restructuring in the ways of overcoming and relieving from discomfort. Undoubtedly, if we account for migration and disease as possible instances of social and individual "breakdown" (Bar de Jones, 2001; Luxardo, 2005), the need arises to analyze the cross-linking of these phenomena in order to gain insight on the interpretations and strategies particular to this social environment.

The paths that subjects must follow to soothe a disease, pain or suffering, reflect their way of seeing the world and organizing their own existence. These paths, or *therapeutic itineraries*, are formed by the set of beliefs and practices that take place at that particular time. Sindzingre (1985) defines them as the series of processes involved in the search for a therapeutic solution, initiated after the appearance or perception of a problem. They are configured from all the decisions, conscious or not, that a person or group makes to face a discomfort. These decisions may cover both inaction and models of care with multiple degrees of complexity, either self-administered or provided by third parties.

A therapeutic itinerary is also an interplay of different interpretations and cures that correspond to the social uses of disease and the way in which the biological, social and cultural are linked (Perdiguero, 2006). In this way, care paths become a fundamental part of health/disease/care processes. The way in which they are configured will depend on some factors, such as the available possibilities of healing, the ease or difficulty of access to said healing, cultural beliefs and habits, previous experiences, and personal and group expectations.

This research aims at describing and analyzing the different strategies in the process of striving for health and disease relief in the scenario of Latin American immigration in Spain. It is focused on the perspective of the participants and their discourse, so as to partake not only of the description of the practices but also to the constructions and meanings around the experience of becoming ill in another country.

In Spain, the arrival of migrants from other countries grew exponentially a little over thirty years ago. Currently, the advent of economic crises such as the global financial depression of 2008, confrontations within and among nations, and the increase of nationalist sentiments around the world have transformed and hindered the migratory experience. As Moreno-Preciado (2008) points out, the presence of "external" people has been instrumentalized by the political and media discourse as a scapegoat for diverse problems. At the same time, the tightening of government regulations regarding permits for entry, permanence, and access to social benefits creates situations of greater exclusion and inequality.

Since 2012 and up to 2018 —as part of deliberate measures taken for economic adjustment and control of public spending—, the Spanish State only guaranteed public health assistance to foreigners holding residence permits. Unregistered or unauthorized persons could only be assisted in case of an emergency due to serious illnesses or accidents. Immigrants under 18 years old and pregnant women, regardless of their administrative situation, had the right to receive health care on equal terms as the Spanish population. The legislative change of 2018, which decreed universal healthcare for all people living in Spanish territory, nowadays presents ambiguities in its implementation, which have been denounced by numerous national and international organizations (REDER, 2019).

The Latin American community is strongly represented in the Spanish territory; it corresponds to the second largest extra-European community, after the African community (especially from the Maghreb) (National Statistics Institute, 2017). The meeting of multiple nationalities under this major regional name requires a series of preliminary reflections, in order to understand the usefulness of this categorization. Undoubtedly, heterogeneity is one of the main characteristics of the migrant Latino population; a natural extension of the diversity present in their continent of origin. However, *being Latin American* responds to a collective identity category of recognition and self-identification for immigrants, used several times in the discourse they build about themselves. Among the phenomena of interest for this research, we can pick back up and highlight the significance of this as an identification strategy expressed within the social group, associated with common values, practices, and ideas that exceed the borders of each country and partake of a larger entity. In many cases, the ascription to an extra-national identity allows for a greater network of links and reciprocity to be established, since the subjects are taken as a part of the same group with similar experiences (Rossi, 2012).

The Latin American migration process is particular since its participants share the same language with the society they arrive at, and there is a —identified by themselves— common cultural root as a result of the historical relationship between both territories. However, there are also divergent cultural elements that create the idea of *being Latin American* as different from *being Spanish.* These points of contact and divergence make their migratory experience a distinctive context in which to study health/disease paths and the evolution of their insertion in the new space. Therein, the different forms of use and articulation of assistance models (institutional, alternative, domestic and popular) are simultaneously erected as forms of resistance, identity revitalization, negotiation and adaptation to the new living environment.

METHODOLOGICAL NOTES

This work is based on an ethnographic research carried out in the autonomous community of Castile and León, mainly in the region of Salamanca and its surroundings, during 2016 and 2017.

A qualitative study based on the phenomenological approach was designed (Schutz, 1967) to describe and understand the health/disease/care experiences of the Latin American population residing in the area. The selected informants were thirty-five adults (twenty women and fifteen men) aged between 29 and 75, from Bolivia, Brazil, Colombia, Honduras, Mexico, Peru, the Dominican Republic, Uruguay, and Venezuela; all under different administrative regularity situations (irregular, holders of temporary residence permits, long-term residents, nationalized and asylum seekers), staying in the country for already one-year minimum. Most of the participants were found through local community organizations, while others were contacted by references from other informants. In order to preserve their identity, the names presented in the testimonies are fictitious.

Intensive fieldwork was carried out using participant observation techniques and conducting semi-structured and in-depth interviews. To guide the interviews, a thematic model was established that addressed the following core concepts: health/disease/care conceptualizations, habits related to the treatment of illnesses, therapeutic choices, preferences and experiences before and after migrating (changes, permanence, negotiations and available resources). The same structure was employed for each interview, adding new questions based on the particular stories. Most interviews were conducted individually, except on three occasions when participants requested to attend in company and be interviewed in groups. Each conversation was recorded in digital audio with the consent of the interlocutors and then transcribed verbatim for processing. These transcripts and their corresponding field notes formed the main body of data to work with throughout the research.

The analytical method selected was thematic analysis (Boyatzis, 1998; Braun & Clarke, 2006; Guest, MacQueen & Namey, 2012), by means of elaborating systematized codes based on the topics of the guide questionnaire and in new emerging categories based on the participants' discourse. The emphasis on particular stories seeks to deepen on the specific meanings, values, and practices at interplay in individual and social health processes (Kleinman, 1980).

This analysis corresponds to a first approach to the subject, within a major ongoing research on the multidimensionality of the therapeutic itineraries of Latin American migration in Spain.

CARE ITINERARIES WITHIN THE CONTEXT OF MEDICAL PLURALISM

All human groups have what is known as "illness behavior"; that is, a variety of possible responses to what is perceived and identified as a malaise. As Haro-Encinas points out (2000), the dynamic nature of health actions is subject to "both temporary decisions, class habits and cultural patterns, which gives it a complex character that needs to be particularized and contextualized in each individual or collective case" (Haro-Encinas, 2000, p. 142). The beginning of the health search process —alleviating the disease, or therapeutic itinerary— is established merely upon the appearance of certain symptoms, the assessment made of them and the consequent decision to act (or not) on it (Perdiguero, 2006).

In this regard, Chrisman (1977) pointed out a series of usual steps taken in the search for health, although they do not necessarily appear in a sequential or complete structure. Its description includes the definition of the symptom or symptoms, changes in behavioral roles, consultation with other people (professionals or laypeople), the use of treatment practices and finally, the follow-up to them. Beyond any possible seriation, the assistance occurrences that take place in each case will be strongly related to the explanatory models that arise at that time (Kleinman, 1980). From this, that which individuals do, who they consult and how they carry out the treatment will depend on how they perceive what is happening to them and to which causes they attribute it.

The study of the health/disease/care processes of Latin American migrants in Spain is framed within a structural phenomenon of the globalized world: the pluralism of medical systems and models. We understand *models of care* as to those activities related to the conscious care of ailments, either through prevention, treatment, control, relief and/or cure. Therefore, medical pluralism refers to the articulation within a society of different care and therapeutic instances, whether officially recognized or not (Perdiguero, 2004).

The different systems of care that operate in a given society are related to its economic/political, religious, ethnic, and technical status. By means of relationships of alternation and complementarity, the needs and possibilities of different groups can lead to a dynamic conjugation between elements "paradigmatically" seen as antagonistic. According to Hernández-Tezoquipa, Arenas-Monreal, and Valde-Santiago (2001), this responds to the principle of pragmatic efficacy that is a common part of the health/disease/care processes.

Studying this phenomenon, Menéndez (1992) developed different models for typifying the main medical systems that operate in capitalist societies. These are a) the hegemonic medical model, b) the subordinate alternative medical model, and c) the self-nursing medical model.

Biomedicine can be categorized within the first, characterized by biologicalism, individualism, formalized professionalization and ideological identification with scientific rationality "as a manifest criterion that excludes the other models" (Menéndez, 1992, p. 102).

The second model is represented by practices seen as "traditional" or "popular," and also by those defined as "alternatives." Naturally, this encompasses a wide variety of activities organized and structured to different degrees. The author acknowledges that many of them are clearly influenced by the hegemonic medical model, and poses their relationship from subordination and/or complementarity.

Finally, the third model stands as the one based on the direct action of individuals in the diagnosis and relief of diseases; it may involve other people in the family and community environment, but it is characterized by the absence of professional resources. This last model is actually the first real level of care in all societies, and may or may not coexist with other therapeutic proposals (Menéndez, 1984). This type of care, alternatively designated by Haro-Encinas (2000) as *profane care* or *lay care*, combines the actions of self-care, self-nursing, and self-help in terms of health and illness.

This research's description and analysis of therapeutic itineraries shows to what extent these three models are present in the health-seeking process of the Latin American migrant collective in Salamanca (Spain).

GROUP-LEVEL CARE: THE SELF-NURSING MODEL

In the process of reconstructing therapeutic itineraries —through interviews and observation activities— it was found that *lay care* enters almost immediately after the identification of an ailment. Most informants acknowledged their preference for trying to alleviate health conditions by their own means, either through knowledge of their own or their families, knowledge acquired through experience or by trying new *ad hoc* options. Therefore, as a starting point, the "severity" of the disease is usually assessed according to a personal (or social) scale, which determines the range of possible actions and the degree of autonomy to carry them out:

> It all depends on the type of illness you have. Because, if it’s only mild... Well, fortunately I am quite healthy, right? There’s been no need for me to go to the doctor very much around here. Because if it's the kind of illness that I know I can handle, well, I’ll take care of it myself (Eloísa, Colombian, personal communication, December 13, 2017).

Folk medicine home treatments —especially aided by botanical or home available resources— constituted a strategy highlighted by informants. Resting in bed and additional care in food or hygiene were also widely mentioned, altogether with the idea that the body must naturally restore its balance. Many of these healing practices were learned in their countries of origin, and according to availability, replicated after migration as part of the care habits of the entire group at home:

> Coca tea. Yes, when we have a bellyache we drink coca tea. It is made from coca leaf. You prepare tea, regular tea; you drink it hot and the bellyache is relieved. But it is amazing; it works. Yes, Yes. It is not nonsense […] Now that my older children are here, they tell me that I am a *yaya*, that I want to heal them as if I were a witch doctor... But I just tell them that it works. Well, my daughter lets me cure her; she does or takes whatever I say. She doesn’t like going to the doctor, since that time... she’s afraid. She thinks they are going to tell her that she needs surgery, and she doesn’t want that. If I tell her “drink this,” she drinks it (Felicia, Bolivian, personal communication, August 22, 2016).

Therefore, it can be said that it is in the family where the highest occurrence of ailments, diagnoses, care, and healing activities is, therein we can identify the beginning of the *patient’s path* (Menéndez, 1993). On certain occasions, the family represents the only possible space for health intervention, which grants their care functions an even more important value than that of formally established or professionalized systems (Haro-Encinas, 2000). Additionally, the way in which different cultural health models are employed in the treatment of a condition will largely depend on the functioning of families and the resources available for the given group (Kleinman, 1980; Menéndez, 1993).

Specifically, migratory displacements can affect the structure of the family unit, by locally reducing the number of members, and therefore also the domestic network of links for alleviating health issues. This can complicate matters, as it minimizes the available resources (particularly so when there are members of the nuclear or extended family in charge of care duties for the group) and increasing the feeling of discomfort and helplessness in face of an illness. As alternatives, favored by improvements in telecommunications, new forms of “therapeutic” connection and networking have been established with those who are far away, allowing for an international circulation of healing advice and recipes, along with remote healing and spiritual requests (Escandell & Tapias, 2010). This form of care was mentioned on numerous occasions during fieldwork.

Regardless of the possible processes of change and adaptation, the application of popular lore to the care of diseases remains a recurring element in social discourse, providing diseases with meaning and aiding in the development of identities. Among the members of the migrant community, there is a certain apprehension in telling about these practices to the native population, or the health personnel of medical institutions. The association of popular therapeutic actions with superstitions, lack of education or lower social strata results in concern or fear of being judged and ridiculed. However, through this work we have been able to recognize how widely they are taken into account as one of the main therapeutic strategies of this population group. To explain this preference, participants mentioned the historicity and effectiveness of, and faith entrusted in, tradition:

> It is that you have believed... that popular wisdom that you have believed for so long and perhaps it is merely comforting. Whether it's true or not... you don't bother confirming... (José, Dominican, personal communication, June 17, 2017).
>
> I leave the newspapers with the ointment on and dress him on top. It will work then, supposedly. As we believe in those things they teach us, then we put faith on it, and luckily, thank God, many things have worked (Felicia, Bolivian, personal communication, August 22, 2016).

At the same time, the knowledge and use of these strategies was valued as an expression of self-reliance, a quality that is seen as "the Latino way." It can be said that the idea of having certain cultural attributes, useful in the face of adversity, is part of a frequently appearing resource that helps migrant groups adapt to their new social sphere, centering themselves around their own resilience (Hernández-Pulgarín 2016).

The Self-Medication Resource

Yet another practice widely recognized within *lay care* by the interviewees was self-medication, by way of taking medicines acquired without prescription, as well as leftover medicines from old prescriptions. According to the research, analgesics and flu medicine are usually the most used for the treatment of frequent conditions such as colds, stomach aches, and fever:

> Well, if I have the flu, I know what medications I need. If it's a stomachache, I know what medications I need. I mean, I can find that medication in my mother's house, in my parents' house (Eugenio, Mexican, personal communication, November 27, 2016).
>
> If it's a cold or something, it's true that's not ideal, but I choose self-medication... Grandma's infusions or things like that... Tylenol, you know if

> it's not something serious it won't hurt you (Roberta, Brazilian, personal communication, February 15, 2017).

As Menéndez (1982) points out, the care of the disease through self-medication is a complex and widespread phenomenon occurring in all social strata. It relates to the frequency, continuity, and recurrence of disease episodes, while also responding to the need of primary groups to act immediately and relieve discomforts, even if temporarily.

Although self-medication is commonly explained by the growth of the pharmaceutical industry and the influence of mass media, it factually is a multicausal event, which must be studied taking into account the specific living conditions of each group. In the case of the migrant population, the frequent limitations to medical access, especially for those individuals under irregular administrative condition, can be taken as precursor factors for self-medication practices. In such cases, visiting a pharmacy is the closest self-managed route for accessing some type of biomedical treatment.

The testimony of Valentina, an irregular Honduran migrant, who at the time of the interview was fifty years old, tells of how this resource comes to be taken into consideration. After having supplied medicine for high blood pressure in her country, and without being able to go to the hospital for new prescriptions, the possibility of asking the pharmacy for help when she no longer had medicine was raised as a way to cope with the anxiety and uncertainty about her health:

> Because when you have high blood pressure it gives you a tingling in the head or a headache... Then, I thought "when I no longer have pills, I'll go to any pharmacy and ask"… (Valentina, Honduran, personal communication, March 7, 2017).

Opting for self-medication was found to also be related to bureaucratic complications in visiting physicians, economic difficulties to pay for consultations, and the delays in or predictability of the response of professionals:

> I don't know if it's about saving money, we don't have any other options. So I tell you, I'm not going [to the hospital] just to be prescribed Tylenol... I already have it at home. I have 600 and 1,000-milligram pills, in case I need them. If my son feels very bad, I give him a 1,000-miligrams pill, just like that. The first day I give him a pill every six hours, and then I decrease the dose. On the second day, I see if he feels better and if so, I give him a pill every eight hours. On the third and fourth day, I give him a pill a day, and then he drinks the typical lemonade. Yes, it's the first thing I do, because I know what the doctor will prescribe, so I rather step ahead and do it myself (Felicia, Bolivian, personal communication, August 22, 2016).

Furthermore, daily activities and work demands require uninterrupted compliance and response, and so self-administered medicines represent a quick solution based on this need.

Several testimonies referred to the use of specific medicines and medications from their countries of origin. When enquiring about it, we were told that many of them had been brought directly by the interviewees, either on their initial migratory trip (as a supply) or after subsequent visits. Transnational therapeutic networks also seem to operate in this context (Krause, 2008), by means of mail shipping among relatives or asking other members of the migrant community who temporarily return to their region of origin. The medications mentioned include ointments, salves, tablets and solutions for the treatment of multiple conditions. As Meñaca (2006) suggests, the use of foreign medicines for disease care symbolically expresses the strengthening of ties in the transnational family:

> Yes, sometimes my mother asks for the ointment to be shipped... *Mentisan* that is. It's always that... and maybe something else that I can use with my nephews when they... for example... when they have nasal obstruction... She asks my aunts and they send it (Juana, Bolivian, personal communication, December 5, 2016).

In other instances, the personal collection of medicines follows from the frequent movement of people around expatriate individuals. In solidarity with those established in Spain, temporary visitors participate in the supply giving them their own spare medicines (or "first aid travel kits"). As Eugenio said, the benefit of accumulation is not only individual, since redistribution to other nearby migrants also occurs:

> If I show you right now my medicine bag, I have medicines from friends who come and go and give them to me. So I also am like an apothecary of sorts, because everyone knows that I have medicine... (Eugenio, Mexican, personal communication, November 27, 2016).

Some of these commercial compounds have been in the market for many years and constitute true national and cultural symbols (as is the case of *Mentisan*[3] in Bolivia, which has had such staying power in the market and is so widely used among the local population that is even represented on official stamps). The value of these products was brought up by several interviewees, who in addition to highlighting their medicinal properties, stressed their regional popularity:

> Whenever someone goes there, I say "Hey look, please bring me some *Mentisan*." I ask nothing else; I say "bring me whatever you want if you feel like, but bring a *Mentisan*." Because in Bolivia *Mentisan* is amazing, all the people... You get a small cut and you use *Mentisan*. You injure your leg, knee, whatever, and you use *Mentisan*. Or if you have a headache, you apply a little *Mentisan* on the forehead. Or if you have a cold, "eat a little *Mentisan*"… You can eat it too, a teaspoon of *Mentisan*, and you also massage and rub it on your chest, back, and all that... Problem solved! […] I think *Mentisan* is one of the

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[3] Over-the-counter commercial ointment produced in Bolivia indicated for the treatment of flu, colds, rheumatic pain, wounds, and insect bites; among its ingredients are camphor, menthol, and turpentine, as well as other essential oils not specified by the manufacturer.

> things that has always come handy for poor people. They have had so much faith that they heal (Felicia, Bolivian, personal communication, August 22, 2016).
>
> Well, we do have a cure here. An ointment that we bring and we use it with my four-year old daughter. Thing is, they don't have it here... there is no ointment with those ingredients. It's an ointment that is used for eczema, for scars, let's say... It's called *Dr. Selby*. It is very famous in Uruguay. And we bring it over here and it's miraculous (Francisco, Uruguayan, personal communication, April 13, 2017).

Among the reasons provided to explain the persistence in their use are trust and specificity. As they are "classic" commercial products, their market stability grants them security, and they are part of the established treatment habits. Among all the conversations and interviews, it was the individuals with the longest stay in Spain who mostly reiterated the use of medicines from their countries of origin. In migrant groups such as the Latin American, the use of these medicines, as well as popular medicine practice, represent the continuity of an identity element that unites them back with their countries of origin and with the people who are still there.

Institutional Care and its Place in the Therapeutic Itinerary

When self-care strategies are not satisfactory or sufficient, informants referred to visiting professional physicians, mainly from the field of biomedicine. This area includes public benefits offered by Social Security, emergency systems and private medical consultations provided by health insurance companies or paid by the user. To a lesser extent, visits to professionals from other care systems, such as homeopathic doctors and acupuncturists, were mentioned. In the reports, it was possible to identify that these visits generally take place after a waiting period that may range from four to ten days, during which the sick person or their relatives evaluate the progress of the ailment. According to what they stated, they always wait for the ailment to be relieved by natural course or for the previously noted measures (self-care) to take effect:

> I always wait... one, two, sometimes up to eight days, if I see that it definitely did not heal or that I did not find the solution, then I go to the doctor... We always wait, but when we don't know how or why the pain is not relieved, we go to the doctor (Alfonsina, Mexican, personal communication, November 10, 2016).
>
> I said, "four days before worrying," and then I go to the doctor (Eva, Venezuelan, personal communication, September 17, 2017).

Some conditions were directly referred to as biomedical matters, particularly cancer and heart conditions. Immediately visiting the doctor -without previous actions- was affirmed in these cases, as well as in those episodes of pain/symptoms that are not recognizable, or not associated with previously experienced conditions.

On the other hand, numerous individuals indicated that visits to the doctor were undesirable; they did not feel comfortable nor did they consider that they would get relief from their discomforts. For many of them, visiting the doctor is undesirable, so they try to avoid doing so by employing other available resources. Some of the informants argued that it is not a comfortable and satisfactory space that favors the relief of their discomforts. Others expressed fear or distrust in attending clinical consultation, under the idea that it can lead to further problems or diseases:

> When I get sick, the first thing I do is not visiting to the doctor... Because if I go, I bet he says "you have something worse" (Francisco, Uruguayan, personal communication, April 13, 2017).
>
> Yes, I don't like it. I mean, it makes no sense to me. And I don't like that, because they will always give you something... They are always going to give you some pill… Then you are going to get used to that and think you have to take some pill all the time… (Eva, Venezuelan, personal communication, September 1, 2017)

As mentioned earlier, the organizational structure of the institutional system is also seen as inconvenient, especially due to its high degree of bureaucratization. In addition, the interviewed considered that they were wasting time due to delays in getting consultation turns and difficulties in accessing specialized doctors directly. In an informal conversation, a woman recalled her frustration after a recent visit to the emergency unit: her oldest son had several days with abdominal pain, which was getting worse over time; after seven hours waiting in the emergency unit, the youngster was prescribed analgesics without having been checked (*paracetamol*) and sent back home. This medical prescription was perceived by the family as insufficient, and besides worrying about their child's health, they were unhappy about the dehumanized treatment. In the same vein, another informant expressed his disappointment towards a seemingly complex and technical system that frequently prescribes cheap treatments in a generalized way:

> [Regarding what to do in case of illness] I just let it be. Yes, because whenever I have a headache or something in my throat, never, hear me, never would I even think about visiting the doctor. I have accompanied people to the doctor and they are just given ibuprofen (Eugenio, Mexican, personal communication, November 27, 2016).

According to other interviewees, professional care had become a business that stopped caring about the welfare of patients in favor of obtaining greater profits. The possibility of consulting the doctor and having to visit him repeatedly thereafter was another cause of recurring complaint:

> It's a matter of profit: doctors now will prescribe you a treatment that then leads you to get another one and so on, so when you realize you go "*no way!*" (Alfonsina, Mexican, personal communication, November 10, 2016).

At the same time, the economic factor was recognized as influential in the process and the choice of therapeutic method, both in the country of origin and in the host country. Popular or alternative medicine comes to the front as desirable options due to, among other reasons, their greater affordability or the characteristics of their care.

> People know that if they go to the doctor they have to pay the consultation, the medicine, whatever else... And if you have to go back you have to pay again... so what people do is go and look for this plant, they cut some, and depending on whether they need it for an arm or leg, they rub it with an oil... *cuchi* oil too, because they extract oil from the same plant... they rub it, put it in there (Felicia, Bolivian, personal communication, August 22, 2016).

> The doctor is avoided. I do that myself. It is very expensive, medicines are very expensive and then I think: "I don't know if I better look for the solution elsewhere…" And yes, I always look for alternative medicine (Alfonsina, Mexican, personal communication, November 10, 2016).

In contrast to biomedicine, some subjects underlined as an alternative consulting with homeopathic doctors, acupuncturists or holistic medicine professionals, which is recognized for its personalized attention and time devoted to consultations. The possibility of emotional relief and the sense of security are perceived as contributing to the improvement of health, even more than any specific clinical treatment. The preference for natural medicine was also expressed in rejection of the consumption of industrial medicines and the excess of prescriptions that go hand in hand with the hegemonic medical system. Different interviewees indicated their concern about the potential side or long-term effects of drug use, associating chemicals with toxic and harmful substances that could cause other diseases in the body:

> I don't know much... I don't like the idea of taking pills. I prefer natural things. I drank my lemon tea with honey during those days... and ginger. And well, you see, then I went to the doctor and he prescribed antibiotics, which I don't like to take. I did take them for a few days, and I think taking those antibiotics was what caused my headache (Eva, Venezuelan, personal communication, September 17, 2017).

> I prefer infusions. I really like natural medicine, making drinks, herbal infusions... I try to... Chemistry I don't like... It always brings something bad, always […] I took a lot of medicine, you see, a lot of chemicals, a lot, but... I don't know, I think that in the long term it hurts and intoxicates the body and it may relieve you from what you have at that moment, but it hurts you in other ways. The liver… (Eloísa, Colombian, personal communication, December 13, 2017).

The Health/Disease/Care Process as Adaptation to the New Environment

Just like certain continuities (such as those mentioned on the use of Latin American popular medicine), we were able to identify transformations in disease care processes after migration, especially in relation to the use of health services. The interviews showed an increase of said use over time, specifically in those migrants with more time in the country. Achieving administrative regularity and using the public health system proved to be a desirable condition for many, reducing their concerns about possible serious health problems. For others, on the other hand, access to biomedical care even became problematized by associating it with a change in the way of getting sick, the loss of autonomy and the acquisition of new dependencies.

> I didn't think I was going to go to the doctor so quick... and I told Ana "It all happened since I got that damned card they ask…" Yes, because I never had it before and I never got sick. Now that I have it, now I started to get sick (Eva, Venezuelan, personal communication, November 17, 2017).

Used to solve matters by herself, Eva now feels that she visits the health centers for the slightest discomfort, due to an external indication from the NGO staff in charge of her International Asylum case. When asked about it, she said that she would normally wait longer before going to the hospital, but she thinks "this is how things are in Spain." Likewise, a woman from Mexico pondered on the adaptive value attributed to the use of health services and the way in which this practice represents an attempt by the migrant population to emulate what is usual in their new environment:

> I know women, Latinas from my group, many of them often went to the doctor as a means to show... as a consequence of the example of how people do it here. People go to the doctor. Everyone goes to the doctor. You go to the doctor, if you feel bad you go to the doctor, and you take medicine. And when you arrive in a foreign country, the first thing you do is look at how other people act... So that "I often go to the doctor" attitude surely also is a way to adapt to your surroundings… a consequence of how the people born in Spain do it too... we are copying, we are adapting, we are assimilating, so this going to the doctor thing is also part of the culture of the society we arrived in. So you have to analyze it: if you feel like going to the doctor very often, well, why so? It's because that's how it is here. It can be that, right? (Catalina, Mexican, personal communication, November 10, 2016).

Migrants may face a paradox in their new country of residence: on the one hand, public opinion reflects a strong rejection and opposition to the idea that foreigners make use of public health, alleging abuses, demands and a willingness to obtain greater benefits freely (Moreno-Preciado, 2008). On the other, they are asked to make efforts to assimilate, to act in accordance with local reality and to adapt to the way things work. The imitation of cultural patterns, as previously indicated by the interviewee, would respond to the desire to belong to and partake of a society that perceives them as strangers despite similarities. Consequently, the aforementioned changes in itineraries would not only reflect the acquisition of rights and opportunities but could also serve as bridges to preventing ethnic prejudices and accusations.

CONCLUSION

The conformation of a therapeutic itinerary comes with a series of personal or group choices that determine the conjugation and/or exclusion of practices and knowledge, according to an expected result. From the fieldwork, it was noted that for the Latin American collective that lives in Salamanca, visits to formal health institutions have not become a prioritized alternative or the first step taken in the path of health care. In some cases, this may be related to structural inequalities that make access to care difficult (for example, lack of legal residence permit). In other instances, specific cultural and ideological elements arise in the discourse, reaffirming the opposition to the Biomedical Model and leading to the choice for other options.

Thus, the importance of self-care strategies as the first real level to alleviate diseases was confirmed. For these people, this form of organization represents a continuation of the medical resources used in their home society, able to respond to the structural differences in access to the institutional health system and to establish itself as a way of replicating the values deemed essential by the group itself, such as reciprocity, heritage, community membership, and autonomy. These expressions remind us that not all migration represents a loss, but also negotiation and cultural claim.

Additionally, ailment management finds a substrate in the network of links and affiliation groups with which cultural meanings about the disease are shared (Pescosolido, 1992). This helps to displace the prevailing idea of individual responsibility for health and to account for a participatory and intricate social structure, both local and transnational.

As Sacchi, Hausberger, and Pereyra (2007) point out, a therapeutic itinerary is a journey "that is not only rational, but is mediated by feelings, memories, sensations, assessments that are not cognitive factors but rather attitudinal and emotional" (2007, p. 277). In short, the use of self-care strategies is part of a way of doing, or *ethos*, able of positioning both the social group and the individuals as active agents in their own health.

Medical pluralism is a pre-existing phenomenon that accompanies individuals from their countries of origin, whit varying degrees of application and extension. The possibility of adapting practices to each disease episode and the alternation in the use of models provides an account of the flexible nature of the itineraries and the pragmatic construction built around healing, which seeks to meet needs as they arise (Leslie, 1980). In the migratory context, however, the presence of the different available devices acquires a unique character, mirroring the way that the new social space is inhabited.

A “bifocal approach” as described by Vertovec (2004) gives an account of the coexistence of intentions and the possible struggle between preserving one’s own cultural practices and the desire/need to adapt to the host society. According to this perspective, migrants and their identities are simultaneously placed between the “here” and “there.” Through ethnographic research, it was noticed that together with the continuity of original therapies, the decision to complementarily visit health institutions responded, in some cases, to matters of social adaptation and integration with the current environment.

The value of social sciences, particularly anthropology, lies in incorporating cultural representations of diseases, their emotional/subjective aspects in conjunction with their social dimension and the context that produces them. As acknowledged by Haro-Encinas (2000), health care and treatment are a daily occurrence, so they should be studied with instruments that allow recording its everyday nature. This can only be achieved if proper interest is put again on the stories of the individuals involved, on their discursive constructions regarding their own reality. What happens behind the walls of a hospital or a primary care center is only a small fraction of a process that begins outside such system, a process with own rules and meanings. The ethnographic approach, especially by the use of qualitative techniques such as in-depth interviews and participant observation, provides an advantage for the reconstruction of the social and individual practices that make up the experience of getting ill and healing.

Translator: Fernando Llanas

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