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The Right to Health of Migrant Children in Chile

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Abstract

The exercise of the right to health for the child population in Chile is a complex issue since some structural difficulties mainly affect migrant children. In order to account for the barriers that migrant children experience in the exercise of this right, a review of the current regulations is presented, showing that international treaties and administrative regulations (decrees, official documents, among others) fail to overcome the barriers they face, given their double condition of vulnerability, due to their age and ethnic-"racial"-national origin. In addition, 31 girls and boys between six and 17 years of age in the metropolitan region were interviewed using a qualitative methodology. Finally, some of their experiences are analyzed in light of previous research on the migrant population's access to health care in Chile, raising some reflections on the particular consequences for migrant children concerning the barriers to access to the national health system.

Keywords: Childhood; Migration; Health; Rights; Social Determinants; Chile

Introduction

Because the pandemic was a global issue, vulnerable and marginalized populations, such as certain ethnic minorities and immigrant groups, as well as people with low income and low socioeconomic status, have been most affected [1]. This pandemic has amplified health disparities among these groups, fueled by socioeconomic determinants of health and long-standing structural inequalities; in this scenario, the pandemic has disproportionately affected racial and ethnic minority groups, with high mortality rates in African American communities [2]. During the COVID-19 pandemic, one group of the migrant population that suffered the consequences of the crisis refers to those in transit or immigration detention centers, especially those for children and youth, because they represent places of mass internment [3].

The Latin American region was affected by the pandemic, particularly in education, as most countries implemented distance education programs. According to some reports, school closures due to quarantine resulted in increased school absenteeism rates [4]. The pandemic mainly affected the mental health of children in Chile. For example, changes in mood, sleep disturbance, aggressive behavior, and psychosomatization were observed [5]. On the other hand, the adult migrant population reported anguish, worry, depression, and not knowing where to go in case of requiring medical assistance [6]. In a European study, a health promotion intervention was carried out to provide

information on correct behaviors to avoid infection [7].

It should be noted that during the COVID-19 pandemic, the migrant population in Chile had access to health care, for example, through the universal mass vaccination program. However, specific requirements had to be met so as to access social benefits, such as having a residence permit and a visa for proper registration in the Social Registry of Households, to be eligible for socioeconomic qualification for benefits.

The arrival of migrant children confronts us with the challenge of analyzing public health policies and asking ourselves if they are designed from a human rights approach, from universal and guaranteeing visions. At the same time, on the contrary, if they are relatively highly focused strategies located in the space-time of a territory delimited by the nation-state, which discriminates and excludes from this right those people who are in positions of social vulnerability. The exercise of the right to health and health care is primordial and related to existing laws, plans, and programs that guarantee or hinder its access. Article 24 of the Convention on the Rights of the Child states that States Parties recognize the child's right to the enjoyment of the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health.

Since the end of the dictatorship, the country has attracted an increasing flow of people that can be explained by social, economic, political, and territorial dynamics [8]. According to estimates by the Department of Foreigners and Migration [9], there are currently one and a half million foreigners living in the country, 20% of whom are children and young people (aged 0 to 19 years). Moreover, the country's northern border is the principal land gateway to Chile. As a result, the Colchane border crossing has experienced a real humanitarian crisis.

There are approximately 300,000 migrant children and adolescents living in Chile [9], although there are approximately 178,060 migrant students in the school system, representing 4.9% of total enrollment.060 migrant students, representing 4.9% of total enrollment, most (58%) are concentrated in public education and to a lesser extent in subsidized private education (37%) and only in four regions of the country: RM, Tarapacá, Antofagasta, and Valparaíso; the countries of origin would be mainly five: Venezuela (26.9%), Haiti (18.2%), Peru (16.1%), Colombia (15.1%) and Bolivia (14.2%) [10-12].

According to the CASEN 2017 survey, the migrant population lives in multidimensional poverty. However, it should be noted that these averages are relativized in each nationality and region of residence. For example, in recent years, there has been an increase in the population living in "tomas" or "camps/slums" or suffering from overcrowded conditions. They generally suffer discrimination because they access more expensive rents and worse living conditions in deprived neighborhoods and territories [13,14]. In addition to poverty and exclusion, in Chile, migrants suffer from the symbolic violence of racial discrimination [15-17]. The Committee on the Rights of the Child [18] recommended that the State of Chile implement measures to seek the social inclusion of the migrant population, promoting the exercise of the rights of migrant children. Specifically, it refers to administrative regularization, facilitating the refugee application process, and collecting updated statistics.

Besides, unauthorized crossings have experienced an increase due to the closure of borders during the pandemic-likewise, the requirement of consular visas under the new immigration law. As a result, more than 35,400 entries through unauthorized crossings were registered between 2018 and 2021, representing 79% of the entries [10]. In addition, it is estimated that in 2020 alone, 1,938 children would have entered irregularly with their families.

In this article, firstly, we will briefly review the current regulations in order to analyze the main barriers to which migrant children are exposed when exercising their right to health in Chile. Secondly, we will present some theoretical ideas regarding the barriers they face due to their double condition of childhood and migration. Thirdly, it presents background information on previous research and analyzes some experiences children have had accessing the national health system, providing data on the social determinants that may affect their health. Furthermore, finally, it concludes with some reflections and conclusions regarding the intercultural barriers their families have experienced (identified in previous research) and how these may affect them.

Health Regulations and Migrant Children in Chile

In this section, we will briefly review some legal instruments that guarantee the exercise of the right to health for migrant children in Chile.

National Law

In 2021, the new Immigration and Foreigners Law Nº 21.325 came into force, which provides access to health care for the migrant population as a way of guaranteeing respect for human rights. In addition, article No. 4 regulates the principle of the child's best interest to guarantee the human rights of children, and Article Nº15 guarantees, in particular, the right to health for the entire foreign population residing in the country, even under conditions of legal irregularity.

International Treaties

In 1990, Chile ratified the Convention on the Rights of the Child, Articles Nº 24 and Nº 39 of which stipulate that all children residing in a particular State have the right to enjoy the highest standard of health and have access to medical and rehabilitation services, regardless of their welfare system or the socioeconomic status of their families. Furthermore, in 2005, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families was ratified, Articles Nº 28 and Nº 45 of which guarantee access to emergency medical care and health services.

Administrative Instruments

In 2007, a technical collaboration agreement was approved between the Ministry of the Interior and the National Health Fund (FONASA), which specifies that those persons whose refugee application is being processed will be entitled to be beneficiaries of the Benefits Regime if they meet the requirements for Chileans.

In 2008, the Ministry of Health issued the Circular (A14, Nº 3229) called "Health care for the immigrant population at social risk and in a situation of non-regular stay," which guarantees the right to health care for the child migrant population, regardless of the legal status of their mothers and fathers. Also in 2008, Exempt Resolution Nº 1.914 of March 2008 and 2009 Exempt Resolution Nº 10.654 of December 2009 were enacted, which guaranteed health, psychosocial and legal care if migrant children had been victims of any violence, as well as access to the public health system and the Child Protection Network.

In 2014 the Ministry of the Interior of Chile and the National Health Fund (FONASA) signed an Agreement (Exempt Decree Nº 6.410, December 1, 2014) that allows access to health services for all migrants who have their regular administrative migratory situation (temporary or definitive residence visa) and also for those who are in the process of administrative regularization.

In 2015, a modification was made to the Supreme Decree Nº 110 of 2004 of the Ministry of Health through Supreme Decree Nº 67 [19], which makes it possible to incorporate migrants who lack documents or residence permits as beneficiaries lacking resources in the Health Benefits Regime. [19]. Supreme Decree No. 110 is the one that establishes the circumstances and mechanisms for accrediting people as lacking resources and indigent. The modification of Supreme Decree Nº 67 adds in Article Nº 2 a fourth circumstance: "being an immigrant person who lacks documents or residence permits, who subscribes a document declaring his/her lack of resources" Furthermore, through Circular A15 Nº 6 of the same year, 2015, Circular A14, Nº 3229, issued in 2008 and widely disseminated in migrant communities, is replaced.

In 2016 through Circular A15 (dated June 13, 2016), Supreme Decree Nº 67 establishes that any migrant person in an irregular administrative situation will be categorized in FONASA bracket "A" which corresponds to persons "lacking resources" and, therefore, have access to public health benefits.

In 2017, Chile's International Migrant Health Policy was disseminated, which declares the principle of universality and is based on constitutional norms, and explicitly alludes to the universality and inclusion of migrants and their daughters and sons.

In 2019, Opinion 1G N° 3/2019 of the Prosecutor's Department of the National Health Fund [20] was issued, which recognizes the access to coverage for foreigners lacking resources guaranteeing care in healthcare facilities. However, a new distinction is introduced according to the new typology of visas. The *tourist* category is introduced to differentiate from *migrants* subject to the coverage benefit, omitting the situation of children. The opinion only recognizes as *immigrants those persons* "whose purpose is to settle in the country". *That is, refugees* may be beneficiaries, but it excludes those individuals in the *tourist* category with an exception: "unless they express their positive intention to stay in Chile, either because the term to be considered a tourist has elapsed or because they have initiated the procedures to obtain a permanent visa."In this way, the ruling left room for interpretation since it did not establish specific documentation to manifest the will to settle. Neither did it offer specifications for those persons who migrate circularly, as is usual in the northern borders of the country, nor for those *seeking refuge*; and what is more serious, it does not establish distinctions for *accompanied*, *unaccompanied* or *transient* children and adolescents, nor the mechanisms to manifest their intention to settle. These are distinctions that, applied without induction within the appropriate timeframe, can generate confusion, triggering the rebound of the migrant and his or her children in the different institutions involved. This final regulation generates situations where there may be cases of arbitrary discrimination on the part of public service officials because it poses operational dilemmas that are difficult to resolve. The modifications to the immigration law resulted in a hierarchization of the migratory "categories" either by their length of residence, nationality, and types of visas. This hierarchization conditions the possibilities of action and access in everyday life [20].

It is possible to affirm that prior to the modification of Supreme Decree Nº 110, a gradual advance of the right

to health for migrant families was gestated as of 2008 because Circular A14, Nº 3229 published that year ensured care for daughters and sons of migrants, regardless of the administrative situation that mothers and fathers had, however, access and use were not adequate. For example, a three-month analysis reveals that during 2017 showed that 24.5% of migrants who tried to obtain an hour in the health system did not get it [21].

As can be seen in this brief chronological overview, the absence of a framework law on migration makes it impossible to guarantee the right to health of migrants in Chile. Nevertheless, a series of administrative instruments have been created to facilitate access to health care and thus comply with the international treaties signed in this area. It must be recognized that this series of administrative instruments have allowed some access to health care. However, this same historical journey allows us to see that the legal instruments can be modified, canceled, or discarded according to the vision of the government of the day, which is why they turn out to be insufficient to guarantee a proper exercise of the right to health for migrant children.

Theoretical Framework

In this study, we will use a sociological concept of childhood and adolescence [22,23] because it is understood that in addition to being vital stages of all human life, they are socially constructed phenomena, variable in historical and cultural terms, but that they constitute a permanent category, although their members are renewed. Today, children and adolescents are seen as mothers' and fathers' property, considering the family the ideal place for their development and protection. However, given the situation of physical dependence (during the first years of life) and economic dependence after that (due to the capitalist system of production in force), power relations based on age emerge, which generates positions of disadvantage and subordination of children and adolescents concerning the adult world, since they depend (physically and economically) on their caregivers/guardians. In extreme cases, situations of abuse of power may occur. In the case of adolescents and young people under 18 years of age, the very concept of "suffering" generates suspicion, but, in addition, since they have developed specific physical and cognitive competencies, they acquire a greater capacity for action and questioning of the adult world [24]. In addition, the generational approach allows us to understand in a macro-social way how age cohorts are affected by certain social phenomena, such as, for example, the pandemic. We are facing an epochal change that certainly implies a generational change. A sociological look shows that this will be a generation marked in the present and future by the health crisis (we speak of a generation of pandemials). In this scenario, it is appropriate to ask how unaccompanied migrant children and adolescents exercise their capacity for agency.

James A, et al. [25] point out that they are social actors and agents, understanding that-based on Giddens' structuration theory - social actors express their agency by acting in a given context that constrains them, at the same time, offers opportunities for social action. Mayall B [26] says that they are agents because they act and produce knowledge and experiences, but children's action has a meaning and develops differently from adult action. Given the intense process of biopsychosocial development, it is evident that their capacity for agency will be delimited by developing their physical, cognitive, and psychological competencies [27]. Child and adolescent agency will be delimited by biopsychosocial development and power relations. This limitation reflects the principle of "progressive autonomy" of Art. Nº 5 of the Convention on the Rights of the Child, a limitation that also operates in exercising their rights. Since the position of subordination impacts power relations, the capacity for agency is developed within a framework of minority action and, at times, socially devalued, representing classic characteristics of a social minority [26]. Thus, in this study, we will understand that migrant children and adolescents develop their capacity for agency through their migratory journey carried out autonomously and, at the same time, we will explore the possibilities of protagonist enunciation, giving space for them to elaborate a discourse on the subject based on their visions, ideas, and feelings. The agency approach is consistent with child protagonist [28], which understands child-juvenile subjects as social actors, who develop a significant, historical, and incident social action or praxis that generates impacts on the social world.

Problem Statement

Initially, the 1975 Immigration and Foreigners Law did not consider the rights of children of migrants, even though under the *ius solis* principle, the children of foreigners born in Chile are Chilean. Therefore, it also needs to visualize the impact of migration on children born in their countries of origin. Although access to rights has been partially achieved through provisions after the law, the effective exercise is conditioned by the fact that social valuation or recognition is not placed on equal terms since they are still considered otherness. However, as already mentioned, in 2021, the new Immigration and Foreigners Law Nº 21.325 was enacted, which declares access to rights for the migrant population, at least at the discursive level.

It is well known that migrant families settle in more precarious spaces [29], accessing lower quality and less equipped services [30]. Indeed, the Socioeconomic Characterization Survey indicates that children between

zero and 17 years old born abroad present 8.5% of multidimensional poverty than those born in Chile (a figure that leaves out the poverty level of children born in Chile but whose father or mother have foreign nationality) [31].

For an analysis of the health conditions of migrant children, it is necessary to know their families' welfare conditions and especially their mothers during the gestation period. In addition, it is essential to consider the conditions of economic vulnerability, the emotional effects of distance and lack of support networks, the stress generated by the adaptation period, precarious work, discrimination, and administrative difficulties that hinder access according to migratory status. Finally, it is necessary to reflect on how these factors can affect the physical and mental health of migrants and their children.

A few years ago, it was typical for migration studies not to register the child agency of girls, boys, and adolescents who were part of mobility processes. The absence of the topic obeys the adult-centric vision of academia which influenced the way of studying the interactions of the most vulnerable subjects, with particular emphasis on the power hierarchies (sex-gender, age, ethnicity/racialization), where they are situated concerning the adult world [32]. The new social approaches to childhood investigate the participation of children in the globality of migration processes and, in particular, in the experiences of violence they suffer in the places of destination due to racism, symbolic violence, and colonial domination, and the strategies they deploy to confront it. All these processes express the power relations in which they participate as social actors, both in their families and the global migratory processes [33].

Methodology

The methodological design of the research is qualitative, the scope is descriptive, and the semi-structured in-depth interview was used to generate data. The sample of people interviewed was obtained through contact with three institutions (public and NGOs) that have Child Care Programs (general and migrant) located in communes in the northern area of the city of Santiago, where migrant families and communities have begun to settle in recent years. The sample of people interviewed was of the opinion-strategic type and consisted of 31 girls and boys between six and seventeen years of age, born abroad or in Chile (but with foreign parents). The information collected was categorized using the computer program Atlas Ti and then tabulated and codified to apply the critical discourse analysis technique. Fieldwork was conducted prior to the COVID pandemic.

In addition, this research was conducted using the child-focused methodology, which guarantees anonymity and respect for children's rights during the study [34]. For this purpose, an ethical protocol was applied through the signing of a child Informed Assent and an adult Informed Consent, following the recommendations of laws Nº 19.628 on data protection and Nº 20.120 on scientific research with human beings (under these protocols, it is made explicit that all the names of the interviewees are self-selected pseudonyms). The interview questions were appropriate according to age and were conducted in pairs to balance the power relationship with the adult research team. During the interview, games and breaks were included, and materials (sheets of paper, and colored pencils, among others) were provided for them to draw the situations they could not or did not want to discuss. Asking children's opinions directly during the research is an affirmation of their right to have a say in matters that affect them, as contemplated in Article Nº 12 of the Convention on the Rights of the Child (CRC).

Results and Discussion

The diagnosis we reviewed above is aggravated, among other things, by the lack of knowledge on the part of migrants themselves about their rights to health in the new context. For example, a study by Galaz C, et al. [35] found that migrant children in Chile are usually unaware of the procedures for accessing local health institutions. A similar finding can be seen in the following quotes from the children interviewed in this research:

> "No, I don't get sick here, I haven't gotten sick, because my daddy says we shouldn't get sick here, because here it's...here we can't take them to the doctor, over there we can, because over there we are born, we are registered in the hospital...I don't know if we are registered in the doctor's office [here]" (Damián, ten years old, Ecuadorian, NGO).
>
> "I had a high fever, I don't know what made me sick, they took me for a consultation at night and they were not going to receive me because my ID card was expired, but they still received me and checked me, they inhaled me and so they prescribed me and I had bronchopneumonia. The doctor was fine, he checked me, he inhaled me" (Alejandra, ten years old, born in Chile to a foreign mother, NGO).
>
> "I don't know what health provision I have" (Daniela, 14 years old, Peruvian, Public Institution for Children).

On the other hand, as we have already mentioned, there is also a need for more knowledge on the part of the civil service about the various administrative modifications and laws that guarantee access to health care. The study by Cabieses B, et al. [36] at the secondary care level reported greater resistance on the part of the health team to assist the public, a lack of knowledge about how to assist the population

not enrolled in the system, and acts of discrimination [37]. All this is in a context where the articulation between the various institutions involved (Investigation Police, Foreigners' Office, health care services) is complex and, therefore, access to health care for the migrant child population is hindered. For example, we can observe the consequences of adaptation in the testimony of a 17-year-old girl:

> "Yes, last year I was hospitalized, for two months, in a mental clinic, something like that... because I had depression. It didn't help me, I don't know, it's just that I feel like I'm the same, like that, it happened when I got here. It's that before I was with my... the same, only I didn't react ugly, like now, that, like I do react ugly, it's like I hurt myself, I hit myself, I [have] cut myself... now I don't cut myself anymore. I was in treatment, but I was discharged, because I was always late for appointments, because my mother works and I always leave late (...). A psychologist, her boss... my mom's boss, gave her that place" (Sofía, 17 years old, Peruvian, public childhood institution).

Findings in the preceding research suggest the presence of biopsychosocial risk factors. These risk factors are essential to consider since it is known that hospital admission can be differentiated-for example, Cabieses B, et al. [37]. In a study of hospital discharges of migrants, for example, an analysis of hospital discharges of migrants was carried out. They confirm that more than 50% of migrant children between 1 and 6 years of age who have left the hospital system come from households with multidimensional poverty - these are households with 25% or more indicators of lack of well-being and a high percentage of these children do not have health insurance (12.7% of children under one year of age, 19.5% of children between 15 and 18 years of age). In addition, more than a quarter of all hospital admissions of migrant children between 1 and 6 years of age are due to trauma. Researchers point out the need to look at such figures from a social perspective. Housing conditions and access to other rights must influence these results. The same study shows that in the 15 to 18 years age group, migrant children tend to drop out of school. In the following quotes, it is possible to anticipate that one of the factors that affect the conditions for exercising the right to education and rest is the proximity to the working world of their parents since childhood:

> "I fall asleep, I sometimes get sleepy, I want to sleep, sometimes I go to my dad's work, sometimes I fall asleep, because he works at night, in the early morning and he works very late and he has to do a lot, he sells bananas, all that" (Verónica, seven years old, Ecuadorian, NGO).
>
> "Here I go to bed around ten or eleven o'clock sometimes, because I don't go to school and I get up around seven o'clock... I feel good, really" (Begoña, 14 years old, Bolivian, NGO).
>
> "At two o'clock in the morning, I go to bed, sometimes I help my daddy to work... I get up at seven o'clock" (Damián, ten years old, Ecuadorian, NGO).

The classification of the social determinants of migrant children's health that it makes Bernales M, et al. [38] suggest specific elements that affect well-being. At a framework level, it identifies, on the one hand, the limitations of social policies to attend to transient children (children of parents in an irregular situation) concerning their school insertion; and, on the other hand, parenting styles linked to authority and a high valuation of sacrifice, the conformation of long-distance families and the need to send remittances to their families of origin [38]. In addition, the authors point out that at an intermediate level, in coincidence with Pavez Soto I [39]. In addition, the authors point out that at an intermediate level, in coincidence with the middle level, there are conditions of poverty, and poverty favors situations of violence, illnesses, and accidents. They also identify risks to the psychosocial stability of caregivers of migrant origin, a condition that directly impacts children, reporting, for example, higher rates of psychomotor retardation. Another need is the scarce evidence on the eating habits of these children in their homes of origin and how the transition of the migratory process would provoke epidemiological changes in a context where childhood obesity has increased. [40].

Through the child protection system *Chile Crece Contigo*, primary health care centers are the first visible face of the health system aimed at children. In this sector, the research by Guerra M, et al. [41] had already revealed confinement to maternity-related benefits due to migratory status and, alarmingly, the existence of negative discourses toward the migrant group (19). These findings reaffirm those attained by Pavez Soto I, et al. [30] regarding relative access, i.e., a lack of recognition of rights and low social valuation of the immigrant *other.* However, at this level of health care, it is more evident to detect barriers of a cultural nature and management of social factors by the work teams. An example of this is Guerra M, et al. [41], who found that health workers perceive migrant women's pregnancies as a strategy to regularize their administrative situation. In the face of evidence such as this, Liberona N [42] warns that access barriers are explained by discriminatory practices by health officials, causing inequalities in access to care and mistreatment. In addition, discriminatory practices by officials can reinforce the ethnicity of immigrants and provoke the emergence of new practices as strategies to exercise their rights [39]. Hence, there is an urgent need for health workers to have a working knowledge of the regulations in force and to raise the awareness of the work teams to respect these regulations, for which they must know the life experiences of users [43].

Regarding barriers to access, the children interviewed in Santiago de Chile did not identify discriminatory practices, but they are unable to recognize the right of access to health care as a public right that belongs to them:

> "The only thing I have seen that provides help is to get a high school where you can study if you are a minor, because there are no health services, I don't know, I don't think there are none. I mean, I don't know if they are public (...) because in Venezuela there is always a health facility where you can go and it is completely free" (Teresa, 16 years old, Venezuelan).

Studies in Chile have found tensions related to intercultural coexistence in the health worker-patient relationship, which is favored by prejudices and language barriers [44]. Considering that the irregular status of some immigrants hinders access and favors ignorance of the Chilean healthcare system [45]. Additional efforts are required to protect people and prevent public problems. According to Cabieses B, et al. [46], one of the most urgent challenges in the face of the brutal violations of rights in health is a cultural competence approach to health associated with the human rights approach. The cultural competence approach proposes an adaptation by health workers to the beliefs, experiences, and needs of each human person to achieve wellness and adherence to health prevention and treatment strategies [46]. Therefore, it is necessary to adapt the protocols for diagnosis and treatment, although it is not enough. Abarca G [47] The ethical implications and scope of the cultural competence model are also highlighted. One of the main concerns of the critique of this model is the position of health workers who have also constructed their cultural difference in validating expert knowledge. The risk of the model is to homogenize the differences among migrants themselves and to constitute them as the *otherness* under the single label "immigrant", favoring a reduction of cultural difference that leads to stigmatization. The researcher argues that the theoretical approach to attachment alone tends to decontextualize psychopathologizing subjectivities without considering social and cultural factors, which could easily be transformed into judgments and violence in medical practices [47].

The risks, as mentioned earlier, lead to questioning the extent to which social intervention devices - including health ones-do or do not allow for the inclusion of migrants [35]. Assuming that, as suggested by the perceptions of health sector workers, it is migrants who must adapt and assimilate the country's culture, two decisive questions arise as they condition any experience of exercising the rights intended by the international community. The first question is whether migrants are recognized as citizens under equal conditions [48]. The second question is whether, 20 years after the ratification of children's rights, migrant children are being recognized as subjects with an effective right to health, regardless of the administrative status of their parents. The results of the research seem to answer these questions negatively. Beyond the normative apparatus, international migrants face the low social valuation of their contribution to Chilean society, which seems to arbitrate their access to rights that are not recognized as their own. It would be even more challenging to discuss children's citizenship status when the Convention establishes their higher good as a priority. A higher good that does not recognize the differential conditions faced by a migrant family in a foreigner society is exclusively seen from an expert knowledge point of view [49].

Conclusion

The right to health for migrant children should be a human rights standard when analyzing the phenomenon of childhood in general. According to the results we have found in this study, we can infer that although there are regulations that have tried to regularize access to services and benefits for the entire foreign population, regardless of their migratory status, it is no less accurate that complicated situations can arise at the window of the Family Health Centers (CESFAM). At first glance, one might think that health services could be overwhelmed by the growing demand; however, the evidence shows a more complex situation since there seems to be a relevant regulatory framework, but infrastructure and human and material resources would be the most vulnerable components [50-52]. In this sense, the present study assumes the complexity of the phenomenon of health and disease as two sides of the same coin, where migrant children and adolescents and their families would not only be responding agencies or "free riders" who would take advantage of the system. Instead, it is a situation that has become more complex as Chilean society has faced new challenges regarding public health and demographic composition. Therefore, it would be expected that the design of public policies would be commensurate with this new reality.

As seen in the preceding pages, access to the exercise of the right to health care for migrant children is mediated by the laws and legal regulations that should guarantee it. As we have seen, although various administrative instruments have been created to guarantee health care for the migrant child population in Chile (Circulars, Decrees, for instance), they do not seem to be sufficient, as they can and have been modified. Undoubtedly, a valid public policy is needed (with framework laws) that establishes health as a right and not as a consumer good; because, in practice, depending on the socioeconomic level, one will pay for and have access to certain benefits or not. Another relevant area to consider

is professional education and training of health personnel and professionals, not only in terms of a culturally relevant approach, which is undoubtedly necessary but also in terms of updating the paradigms on which their practices are based. The predominance of the biomedical approach means that migrant children are seen as evolutionarily incapable beings or only as responding organisms. Progress must be made towards approaches that are "friendly" to migrant children, which see migrant children as protagonists of the experiences they are living and as integral organisms, where illnesses or symptoms are part of integral migratory processes.

To this end, the social determinants that may affect their health in a particular way must be taken into account, for example: Migratory trajectories or dynamics (prolonged settlements, in stages or circular migration), the consequences these have on planning possibilities, how this affects the health of the family group and their access to services; the mechanisms through which children participate in the migratory decisions of their mothers and fathers or, if on the contrary, they are excluded from them, what are the consequences in terms of mental health and how these are reflected in other areas such as the relationship with peers or school performance; housing conditions, as variables that affect the possibility of protecting their privacy, resting or recreating given the working conditions of their mothers and fathers, and how these affect the daily routines of children; and finally, the intercultural barriers that could discourage the proximity of parents to health services and, therefore, hinder the right of children who, since they are generally linked to the services in the company of their parents, may not be able to access them.

Finally, it is necessary to question the foundations of public health policies in order to provide preventive and rights-promoting care to the migrant child population while at the same time repairing and treating what is lacking. For this, it is crucial to pay attention to the migratory trajectory of children, from the time they are left in their countries of origin in the care and company of other people in their family groups or neighborhood networks, then when they make the journey, and finally, once they arrive at their destination, in this case, Chile. At this moment, where the migration issue is on the public agenda, it is necessary to develop and design comprehensive public policies that guarantee the exercise of rights but also go beyond that, not only in terms of access but also aim at fundamental processes of integration and social inclusion of the new generations of migrants in our country.

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