

Childhood and [re]habilitation: pragmatic political realities in the Colombian context

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Abstract *In this article, we outline some intersections between the concepts of childhood and [re]habilitation, which have undergone parallel development, especially since the 20th century. This complex interaction is mediated and constructed from scientific discourses that have consolidated around childhood. We emphasize this analysis from two perspectives: 1) academic positions that, from professions such as physical therapy, speech therapy, and occupational therapy, touch upon [re]habilitation in childhood and 2) public policy perspectives, which tend towards the creation of places to professionally practice [re]habilitation. A literature review driven by the question “What does it mean to [re]habilitate children in Colombia?” is cited in each section of this text, divided historically into 1) the rise of these [re]habilitative professions in Colombia, 2) the decade of the 1990s, marked by great changes through Colombian political reforms, and 3) the technological developments of the 21st century. We conclude that medical hegemony continues to guide the processes of [re]habilitation within a context that has changed and which imposes new challenges and requires new understanding and great conceptual and practical mobilization.*

Key words *Boys and girls, Disability, Speech therapy, Occupational therapy, Physical therapy*

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Introduction

The relationships between the concepts of childhood and rehabilitation have been recently established. Although both concepts have developed in parallel, especially in the 20th century, it is only after significant political acts, such as the Declaration of the Rights of Children, legislation on disability on a global level, and discussions about eugenic policies and theories, that meeting points between the two concepts have been highlighted.

The scientific foundation for rehabilitation mainly began in the 20th century, when its development was emphasized in working with adults, starting with the marked need created by the world wars. The purpose of rehabilitation at that time was centered around returning people to their previous state, with the idea of restoring to them what war had taken away¹. Although the concept of rehabilitation initially emphasized work with adults, it also took into account work with children. Little by little, the concept permeated the daily reality of young boys and girls. Nevertheless, for them, the purpose of the rehabilitation was not restoration but rather to improve the development of capabilities that would allow those children whose particular characteristic was their young age to develop adequately in different contexts. In fact, even today, there are international discussions about the relationship between the concepts of rehabilitation of adults/habilitation of boys and girls².

The difference marked by the prefix “re-” no longer denotes repetition: not only “to once again” habilitate, as in the adult, but rather giving these people for the first time a capability or ability to achieve a better quality of life³. However, so as not to enter into discussions about habilitation or re-habilitation of childhood, which is not the object of this article, we will adopt the concept of *[re]habilitation*, referring to both concepts at once, in the sense that what prevails is the idea of normalcy, of achieving or establishing the greatest level of functionality or independence possible, whether it be in a person who has reached adulthood or not.

With regard to childhood, since the last century, many debates have arisen on this concept and on different relevant practices, each with their own particularities depending on the historical and cultural contexts of each country. Various studies made it possible to recognize children as historical subjects⁴⁻⁷, seeing them as protagonists⁸ in the great matters of history.

In this article, we will outline intersections between the concepts of childhood and [re]habilitation. We start from the recognition that this is a complex interaction, necessarily mediated and constructed within scientific discourses that are consolidated around childhood, giving a current identity that attributes to children a cultural, social, and political content different from that of adults⁸.

The interaction between these concepts could be viewed from various perspectives; however, our interest is to emphasize two of them: on the one hand, the academic positions that touch upon [re]habilitation in childhood in professions such as physical therapy, speech therapy, and occupational therapy. By recognizing their history as professions in the Colombian context, we contribute to the understanding of the discourses that have been constructed around childhood [re]habilitation in Colombia. Consistent with this view, the perspective in public policy not only reveals a current framework for childcare in Colombia but also contributes to the creation of certain places for the professional exercise of [re]habilitation. We start with the basic concept that underlying all public policy are theoretical discourses which themselves respond to collective ideals. Thus, we refer to normativity as the operationalization of politics, understood as the combination of socially constructed and articulated responses to understand, in this case, the needs of people with disabilities⁹. This standard, expressed in laws, decrees, and resolutions in a dynamic and interactive definition of disability, constitutes one factor of the environment that could exacerbate or minimize this condition in people. We are not interested in deeply studying this legislation in Colombia; other rigorous studies should be consulted, such as those advanced by Moreno^{9,10}; nevertheless, the standards that cover disability in childhood have oriented the historical course of these professions in Colombia, showing the intersection between the concepts of childhood and [re]habilitation. The complex interaction of the concepts is illustrated in Figure 1.

In this sense, the policies in Colombia cannot be disconnected from those on the global stage, since entities such as the World Health Organization (WHO), the Pan-American Health Organization (PAHO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), and United Nations Children’s Fund (UNICEF), among others, have been in charge of leading the conceptual and political discussions to establish standards and declarations regarding the care for

both persons with disabilities and children, thus formalizing [re]habilitation programs^{11,12}. Simultaneously, based on the principles of the 1948 Universal Declaration of Human Rights and the 1989 Convention on the Rights of the Child, equal opportunity has been emphasized, which has influenced Colombian laws.

The methodology used to develop this article was a literature review that addresses a) the upsurge in Colombia of health professions centered around [re]habilitation, such as physical therapy, occupational therapy, and speech therapy; and b) the theoretical and political positions that focused attention on childhood in this country, especially since the mid-20th century, the same period that these professions emerged. The question "What does it mean to [re]habilitate children in Colombia?" directed the historical review outlined in three stages. Each stage composes one of the sections of the article that, in conjunction with global recommendations, has led to particular characteristics in the development of childhood rehabilitation in this country:

1) The first comprises the period beginning in the mid-20th century in Colombia, a time when professions such as physical therapy, speech therapy, and occupational therapy emerged. These professions were continually positioning themselves, adapting to changes in health care with professional, scientific, and guild progress. The end of this period is marked by the Convention on the Rights of the Child, signed in 1989.

2) The second segment consists of the decade of the 1990s, marked by great changes based in the political reforms carried out in Colombia, which gave childhood care a particular character. Therapeutic services were defined as rehabilitation, which laid the groundwork for a particular field of action for these professions. The end of this period coincided with the pronouncement of the World Health Organization on the International Classification of Functioning, Disability and Health (ICF) in 2001.

3) The third segment corresponds to the developments of the 21st century. The approval of the ICF in 2001 became a jumping off point to understand the way of thinking in approaching childhood [re]habilitation during this century.

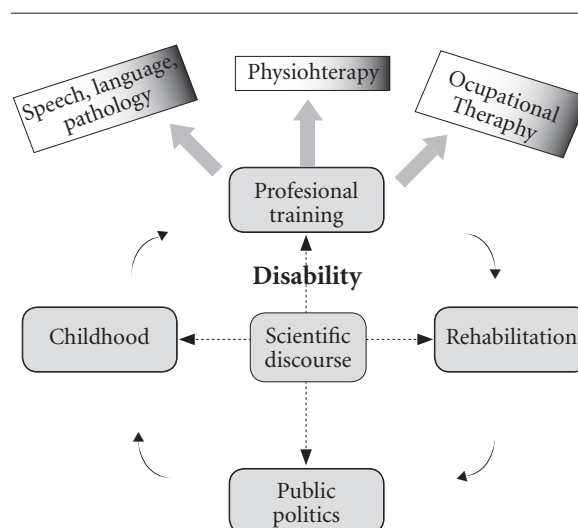


Figure 1. Interaction of the concepts presented in the article.

Source: compiled by the authors.

The context of childhood in Colombia during the emergence of the professions of physical therapy, speech therapy, and occupational therapy

In the mid-20th century in Colombia, concern regarding childhood rehabilitation was increasing. With high infant mortality rates during the first half of the century (from 200 per thousand in 1938 and 120 per thousand in 1951)¹³, a series of measures were adopted by the government to protect this population. These included the assessment of milk quality as one of the principal causes of gastrointestinal illnesses, which was highly discussed in state bodies, such as the Ministry of Hygiene. Similarly, there was continuing uncertainty due to bouts of poliomyelitis in the 1930s and '40s in different cities throughout the country, and controls were carried out for other childhood diseases such as measles, diphtheria, and whooping cough¹⁴, among others.

Additionally, during this same time period, there was an emphasis placed on childhood hospital care, and many children's wards in hospitals were improved and enlarged, such as the one in the Hospital La Misericordia in Bogotá and the San Vicente de Paúl in Medellín (Clarita Santos Children's Ward). Similarly, with a few children's hospitals already functioning in the country because of the consolidation of pediatrics as a medical specialty, including, among others, the Chil-

dren's Hospital Noel Clinic in Medellín in 1924 and the University Children's Hospital Rafael Henao Toro in the city of Manizales, founded in 1937 (originally called *Hospital of the Defenseless Children [Hospital de los Niños Desamparados]*), there was a push to provide more continuity to children's care through this type of institution. For this purpose, more Children's Hospitals were created, including the Lorencita Villegas de Santos in Bogotá, which began functioning in 1955; the Los Ángeles Children's Hospital, located in the city of Pasto, founded in 1952 as a charity institution thanks to the particular initiative of a group of society ladies of San Juan de Pasto¹⁵; and the Napoleón Franco Pareja Children's Hospital in Cartagena, which opened its doors to the public in December 1947, initially as a lactation program for children with scarce resources that then transformed into the Children's Hospital¹⁶.

Similarly, in 1947 in Bogotá, the Franklin Delano Roosevelt Institute for Children's Orthopedics was created, focusing on care for children with physical disabilities¹⁷. It treated not only children afflicted with spasmodic paralysis and congenital deformities but also people with disabilities with multiple causes¹⁴. This institution enjoyed the participation of an interdisciplinary team of orthopedic doctors, psychiatrists, and nurses specialized in the rehabilitation of sick children and other scientific personnel trained to identify those diseases that can cause physical and mental disabilities in Colombia's child population. The purpose of the institution was "to restore disabled persons to the most complete physical, mental, social, or vocational state possible, enabling them to be economically useful, capable someday of providing for their livelihood"¹⁸.

Later, a group of doctors trained in the United States founded the Colombian Society for Physical Medicine and Rehabilitation (Sociedad Colombiana de Medicina Física y Rehabilitación, ACMF&R) in 1963 as a scientific entity and guild¹⁹. Among the important achievements of the Society, the following stand out: a) the official recognition of the Specialization of Physical Medicine and Rehabilitation by the Colombian Association of Medical Departments (Asociación Colombiana de Facultades de Medicina, ASCOFAME), which led to the in-country certification of the first medical specialists; b) the establishment of minimum requirements for the opening of the Departments of Physical Medicine and Rehabilitation in the University Hospitals of Colombia; and c) the catalyst for the creation of

academic programs for physical therapy, speech therapy, and occupational therapy in Colombia. Similarly, in 1968, during the presidency of Carlos Lleras Restrepo, the National Council of Rehabilitation was formed, which included the participation of the ACMF&R²⁰.

Starting with these care initiatives for the country's child population, as well as the consolidation of the pediatric specialty during the first half of the century and the arrival to the country of the first physiatrist doctors educated abroad, the first intersections began to appear among the formal health care processes for childhood [re]habilitation. In Colombia, the history of medical professions centered on [re]habilitation, such as physical therapy, speech therapy, and occupational therapy, had their start in the framework of these events during the second half of the 20th century. In that time period, the discourses of medicine, psychology, psychiatry, and pedagogy positioned their knowledge into individualized and normalizing discourses²¹, which were consolidated into the medicalization of childhood. Later in this article, we will present some historical facts about the emergence of these professions in the Colombian context. The advancement of these three professions, together or separately, allows one to reflect on how childhood is seen and how this has promoted the development of these [re]habilitative professions.

The study of Physical Therapy first emerged in Colombia in 1952, after the creation of the first program in the National School of Physical Therapy (Escuela Nacional de Fisioterapia, currently the Colombian School of Rehabilitation, Escuela Colombiana de Rehabilitación); however, it was recognized that from the first half of the century, its practice was carried out by different, non-professional people, called masseurs and *sobanderos* (folk healers), who supported the incipient practices of the movement begun by a few orthopedists in the country²². This period is known in physical therapy as that of disperse practices^{22,23}. During the emerging period of this program of study, Colombia received a strong influence from northern powers. Thus, it was logical that this program would also have a North American influence, based on the programs of Rochester and Chicago, founded on a biologist-mechanistic paradigm²⁴. The profession's goals at that time were to work with "invalid children" and "the rehabilitation treatment of injured children"²⁵.

Speech therapy emerged as a profession in 1966, when academic programs began at the National University of Colombia and the Co-

Colombian School of Rehabilitation, called the Colegio Mayor de Nuestra Señora del Rosario at that time²⁶. The educational curriculum lasted three years and issued degrees to language therapy technicians and speech therapy technicians. This restricted the graduates of those programs to only working under doctors. The emergence of this profession in Colombia had two marked tendencies in its orientation: towards Europe and towards the United States. The first, which more strongly identified with the medical sciences, increased its task from the phoniatic approach of the otorhinolaryngologists towards finding affinities with physical medicine, finding itself in the area of the medical professions of rehabilitation²⁶. The North American tradition in the discipline was carried out under two working perspectives: on one hand, from the realm of education, supporting students with difficulties in communication, and on the other hand, in rehabilitation services of hospitals helping soldiers disabled in the world wars²⁶. These perspectives caused differences not only in the name and the professional profile but also in the reach and dominance of the profession, which established the basis for future conflicts over unifying criteria that would permit social recognition and national regulation.

With regard to occupational therapy, the first educational program was created in 1966 in the National University of Colombia, under the North American biomedical approach. During the first years of its creation, the field of action was limited to the hospital context, directed towards the treatment of subjects with physical disabilities or psychiatric problems. However, the professional profile widened in later years to include the realm of special education, professional rehabilitation, and occupational health²⁷.

It is not unusual that these professions emerged from a basis in medical models, such as physical medicine, pediatrics, otorhinolaryngology, and psychiatry, professional specializations that consolidated on a national level, and with organizations and associations that were laying the academic and professional foundations for them. Thus, once the university processes began for these professions, they continued with scientific, professional, and guild foundations for the ensuing decades, which is consistent with the dynamics of national development. For this reason, guilds were formed one by one, looking to consolidate and cement the actions of these professions both socially and politically. In 1953, the Colombian Physical Therapy Association

(ASCOFI by its initials in Spanish) was founded as a guild aimed at recognizing and maintaining this new profession in the country²⁸. Later, in 1969, the Colombian Association for Speech and Language Therapy (ACFTL by its initials in Spanish) was formed, which aimed at promoting and strengthening the development of this profession²⁹. In 1972, the Colombian Association of Occupational Therapy (ACTO by its initials in Spanish) was created as a response to the need to promote and consolidate the professional practice and to achieve three essential goals established in its mission statement: progress, science, and technology³⁰.

The health sector's approach to childhood in the decades of the 1950s and '60s, when these professions emerged, began to strengthen due to a change in the Colombian census: in the 1938 census, periods of life were mentioned for the first time, including early childhood (children from 0 to 4 years old) and childhood (those from 5 to 14 years old). Starting in 1967, the population was presented in simple age groups, and thus, the design of health programs for pediatric care was different from the programs for school-aged children³¹. However, this reality gained strength, especially because in the first half of the 20th century, the Colombian population quadrupled from 4.3 million in 1905 to 17.5 million in 1964³². In addition, the mortality rate decreased while the fertility rate remained high, which rejuvenated the population: in 1964, 47 of every 100 Colombians were under the age of 15. Thus, it could be said that over six decades, Colombia had become a country of children.

This reality coincides with the subordination of childhood to structural and organizational processes, such as the nascent Colombian Institute for Family Welfare, created through Law 75 in 1968, which took care of poor children and their families, particularly mothers. Under its auspices, community homes were strengthened, along with protection agencies, adoption houses, detention facilities, and prison annexes, among others³³. These institutions would begin to take on an important role for medical professions, offering more places for childhood [re]habilitation.

During the 1970s, the basic infrastructure of the National Health System (SNS by its initials in Spanish) in Colombia was developed, which required significant capital investment by the state³⁴. Apparently, the orientation of these policies supported the model of "medicalization" that was prevalent in Colombia, which was characterized by direct intervention based on med-

icine and was oriented towards illness and its treatment³⁴.

With the aim of consolidating the SNS, education for human resources for health shifted from a technical level to a university level³⁵. To accomplish this, professions such as speech therapy, physical therapy, and occupational therapy transcended the initial technical training they were created with, and professionalization processes at the university level were implemented. Thus, under Law 9 of 1976, the professional university level of physical therapy was recognized²⁸; in 1978, occupational therapy was recognized as a professional university program with a graduate degree level, which changed to the occupational therapist degree level in 1980²⁷, the same year that language therapy training went from technical training to a professional degree in speech therapy²⁶. At the same time, the language therapy curriculum showed the influences of predominant thinking on language and communication drawn from psychology, linguistics, sociolinguistics, biology, and pedagogy, among others³⁶. This, in turn, clearly employed an approach toward children based on the development theories of these disciplines. Thus, in 1977 at the Catholic University of Manizales, the third educational program was formed in the area, called “speech therapy,” a name adopted by the other programs in that area created after that date²⁹.

The global strategy called Primary Health Care (PHC), understood as “the set of actions designed to meet the basic health needs of communities”³⁷, proposed after the declaration of Alma-Ata in 1978 and strengthened by the Ottawa Charter for Health Promotion in 1986, brought significant changes to the care of the childhood population regarding [re]habilitation. This strategy also signified a new relationship between health and development in the framework of a “new economic order”³⁵. Health programs aimed at childhood were privileged as growth and development programs, which gained great importance in health institutions and became the standard bearer for promoting health and preventing disease in children³⁸.

During this period, a search and formulation of new strategies emerged that were aimed at improving people’s quality of life. For this, it was necessary to understand the process of health and illness not only on the individual level, but as a multicausal phenomenon demanding intersectional attention. Rooted in these changes, the education of the medical professions began to be criticized, especially due to its lack of ties

between medicine and the current necessities of Colombian society. This caused the [re]habilitative professions to begin to venture into the social sector, seeking to mold the professional profile to the needs of social change. In the case of speech therapy, this early action, more than a communitarian program, began as an attempt to decentralize the provision of health care services using student residents. However, *the work carried out by the professionals in this sector was practically limited to carrying out preventative-educational activities in the traditional style, through lectures and conferences, or shifting the health care model through diagnostic activities and therapeutic intervention for linguistic disorders, especially in early childhood, because health care at school institutions and childhood centers was privileged*³⁹.

Continuing the policies around childhood in Colombia following the framework of the SNS, Law 7 of 1979 created the National System for Family Welfare to promote integration and harmonious relations within the family and to protect and guarantee the rights of childhood. Similarly, the Minor’s Code was issued in November 1989, which was based on the elements of the irregular situation faced by children. Its publication was made the same year as the International Convention on the Rights of the Child³³, which was approved by the Colombian National Congress in 1991.

In general terms, during this period, not only were the professions of speech therapy, physical therapy, and occupational therapy created in the country, but they also began to respond to the paradigmatic changes to health care that stemmed from the political and situational developments of the time. However, the decrease in the birth rate from 47.2 per thousand in 1964 to 27.0 in 1985 – evidencing a decrease in the population under 14 years of age by 37.5% – was a reflection of these health programs, including family planning. This marked certain transcendental changes in the configuration of Colombian families as a field of tension at whose center was childhood⁴¹. The demographic and family changes in the country during this period caused even more attention to be focused on the family, such that it became an object of study for Colombian sociologists, anthropologists, and psychologists⁴². For that time, the studies of Virginia Gutiérrez de Pineda⁴³ corroborated the variability of the concept, along with multiple family possibilities, especially in a country with a marked geographic, ethnic, cultural, and social diversity. However, a certain family ideal that offered the optimal con-

ditions for a child's development continued to be perpetuated.

For that reason, the preventative childhood healthcare models instilled certain perspectives, not only towards the family but also about the ideal child that should be constantly monitored during his or her development. Under this scenario, the family became a medium for the purposes of the state, as a collective subject that ought to act upon children.

Dynamics regarding childhood [re]habilitation in the decade of the 1990s

The decade of the 1990s opened with great expectations of working with childhood and continued with the great sociopolitical changes in the country caused by the political reforms, such as the Reform of the National Constitution of Colombia in 1991, the Reform of the General System of Social Security and Health: Law 100 in 1993, and the issuance of the General Law for Education: Law 115 in 1994. These changes amounted to the basis for childcare; they strengthened protections for the family and with it childhood, promoting early education, care, and nutrition programs, among others.

Parallel to these national changes, in 1990, the World Conference on Education for All was held in Jomtien, Thailand, where a global strategy was proposed for Early Childhood Care and Development (ECCD) as well as for early education, with the idea of universalizing access to education⁴⁴. That same year, in September, the World Summit for Children was held in New York, where Colombia also participated. At this Summit, the World Declaration on the Survival, Protection and Development of Children was signed and included commitment for countries to encourage the formation of national plans in favor of early childhood⁴⁵.

In addition, in 1992, as a response to the commitment made by Colombia at this World Summit, national institutions (Ministries of Health and Education and the Colombian Institute for Family Welfare), under the coordination of the President of the Republic and the National Planning Department and with the cooperation of UNICEF, formulated the National Action Plan in Favor of Childhood (PAFI by its initials in Spanish). Essentially, this plan utilized the approaches of the two international events mentioned above and set different types of goals for the decade of the 1990s: global, sectorial, and support, aimed towards problems or aspects of health, nutrition,

preventive care, special protection, education, potable water, and basic sanitation.

The PAFI proposal was developed in the framework of a participatory policy with family and community cooperation, where the function of the State was complementary to that of the family and the social environment of the child. The basic principle was to recognize that the natural and privileged core for the whole growth and development of a child was the family⁴⁶. At the same time, the fundamental proposal of the growth and development program began to consolidate into one of *accompanying and stimulating the child, promoting the ongoing construction and reconstruction of his or her goals of holistic and diverse human development as a base on which to weave resiliency: self-esteem, autonomy, creativity, happiness, solidarity, and health, through active work by the child, his or her family, community, and the health team*³⁸. For this purpose, the group care strategy was proposed, which facilitated the interchange of knowledge and motivated participation. In addition, the programs offered in the health sector were converted into one of the possibilities where adults would receive governmental support related to their childcare work⁴⁷. In this sense, students from the academic programs played a strong role in this program, continually watching the children's development. The Program for Comprehensive Childhood Health (SIPI by its initials in Spanish), created by the Interinstitutional Group for Children's Health in Antioquia in 1993, was formed to achieve these goals, for which purpose the Technical Guidelines were created for evaluation with the Abbreviated Scale of Psychosocial Development (EAD by its initials in Spanish), created by Colombia's Ministry of Health. Later, in 1999, this scale was adjusted with the support of UNICEF: EAD-1 to evaluate childhood development in four areas, gross motor development, fine motor development, personal and social development, and audition and language, to facilitate the early detection of disturbances in children from 0-6 years⁴⁸.

However, 1994 was fundamental in the discussion of inclusive education arising from the declaration of Salamanca; this initiative boosted the concept of educative inclusion, understood as *the integration of students with special needs in normal schools and excluding groups with ethical factors of gender and socioeconomics*⁴⁹. This outlines a global trend that shows the mobilization of care from [re]habilitative processes centered on the body towards an incipient displacement towards the social. This became evident in the

professional development of speech therapy, occupational therapy, and physical therapy, which employed curriculum reform to adapt their programs to national and global changes.

It is evident in this decade how disciplines such as pediatrics and psychology are in charge of individualizing and medicalizing the child, as they are positioned with greater frequency in child health care programs. This caused childhood intervention to be set up within the family, which was permeated by medical and therapeutic discourses, realizing *a new relationship between parents and children, accompanied by an external discursivity in relation with the doctor [...] which made the father or the mother simultaneously diagnosticians, therapists, health agents*⁴¹.

In 1997, in Colombia, Law 361 for the protection and care of people with disabilities was authorized, and the National Consulting Committee was created. In 1999, the National Plan for the care of persons with disabilities was designed with five areas of action: prevention, rehabilitation and social and family integration, work integration, educational integration, and accessibility to information and public space. In the educational field, the program to provide education to children with disabilities was designed and executed, with educative and informational material for the early detection of disabilities and for specialized services. In 1999, the ICBF saw 4,555 children with disabilities in high vulnerability situations in its institutions, along with 2,296 children with disabilities in special foster homes. General guidelines were defined from the perspective of comprehensive protection. Six pamphlets were written, edited, and distributed regarding the comprehensive protection of children with distinct limitations: visual, auditory, mental retardation, autism, deaf-blind, and Down's syndrome⁵⁰. Similarly, the flagship community homes were the children's homes, where comprehensive care was offered to children between three months and five years in risky conditions, and communal kindergartens. In general, this decade saw an improvement in quality of life with regard to services, support for the family, and early education⁵¹.

In this way, the [re]habilitative professions began to develop work that was more consciously centered on childhood. For example, speech therapy recognized childhood work as a response to the need to overcome difficulties in language development, [re]habilitate auditory disorders (hearing loss and deafness), and overcome problems with speaking and acquisition of the written

word, moving hospital practices to schools. They carried out analyses of the physical aspects of the environment, particularly architectural barriers, in which the human occupation was "a dialogue between man and his environment"⁵². However, physical therapy, which from its beginning had been dedicated to solving problems related to body movement²¹, showed a special interest not only in knowing the structures of the nervous system and musculoskeletal system that are involved in movement but also the functionality of these structures when carrying out the roles of the patient in his social group. The aim was to recuperate as much lost movement as possible or, in the case of childhood, aiming for children to achieve motor skills in accordance with their chronological age. These practices were always marked by a subject – object relationship in which the subject is the therapist and the object is the patient, who has little or no participation in the evaluation, diagnosis, and treatment of his or her problem²¹, and they were oriented in social terms towards individual productivity²².

The transient or permanent intervention strategies for persons with disabilities stipulated via the comprehensive social security system were deficit-based and traditionally marked by the search for functionality in an individual physical dimension. In the same way, the possibility of ambulatory care was contemplated when people were not independently able to attend doctor visits⁵³. According to this concept, functionality is still being sought, and the individual and the biological stand out in the care of the subject, emphasizing his or her condition of dependence.

From these guidelines for action, the call was also for the university, as the center of knowledge production, to encourage reflexive and intellectual processes to bring in the family in contributing to development and guaranteeing efficiency in programs of family care⁴⁶. Faced with an excess of training programs for professional health care workers, the need to use mechanisms such as self-evaluation, accreditation, certification, and curricular innovation was stressed, with the aim of compensating for the problem of deteriorating teaching quality³⁵. Given the proliferation of the [re]habilitative professions in different universities and regions in the country, an era of creating associations began, which would bring together university departments with the aim of regulating them. Thus, the Colombian Association of Departments of Physical Therapy (ASCOFAFI by its initials in Spanish)²⁸, a Speech Therapy association (ASOFON by its initials in Spanish)⁵⁴, and

the Occupational Therapy agency (ASCOFACTO by its initials in Spanish) were created in 1998, 1999, and 2000, respectively.

In these ten years (1990-2000) in Colombia, in addition to the intersectional and interinstitutional coordination for guaranteeing the rights of the child, territorial governors included policies and programs directed towards the family and childhood in their development plans for the first time⁵⁰. In conclusion, we highlight the transition from a biomedical perspective towards a preventative social model, instilling the concept of health as a right of citizenship. Even still, the road to consolidating these processes is long, which opens up possibilities for policies acting on childhood in our country to develop over the next century.

The 21st century and the [re]habilitation of childhood in Colombia

Given the dynamic described in previous decades, the perspective on childhood care in the [re]habilitative processes in the 21st century began with the WHO's approval of the International Classification of Functioning, Disability and Health (ICF) in 2001. This new international model of disability is based on the recognition of disability as a condition that is composed not only of the structural aspects of the individual but also of the interaction of the individual with his or her environment. From this perspective, disability is understood within the interaction between people who suffer an impairment and contextual (personal and environmental) factors⁵⁵.

The ICF is presented as a dialectic posture between the *medical model*, which considers disability as a problem of the person directly caused by an illness, and the *social model*, which considers the phenomenon fundamentally as a problem with social origin, where the central axis is the integration of the person into society⁵⁵. The biopsychosocial position presented in the ICF integrates these two models, where disability includes impairment (medical model), the limitations in activity, or the restrictions on participation (social model). According to Ferreira⁵⁶, this new version aims to overcome certain preceding deficits:

i) *The causal connection between impairment and handicap; in fact, the old terminology is abandoned: instead of the triad impairment/disability/handicap, now the shortlist functioning/disability/health would be used, the first being the generic*

term for the functioning of the human being, the second representing a relatively low gradation in some aspect, while the third would be the connecting bridge between the two.

ii) *A positive terminology would be adopted: instead of opposing disability and "normalcy," it would be stipulated as a relative gradation of human functioning, and thus, the three levels of the ICF would be transformed into structures and function/activity/participation, which consider in positive terms the biological substratum, previously "impairment;" the individual level, previously "disability;" and the collective, previously "handicap."*

iii) *The intention is universal applicability: instead of a classification of handicaps, a typology of the states of health would be established that is applicable to any human being, with persons with disabilities being one part of the reference spectrum.*

iv) *Above all, it would take into consideration "environmental" factors as significant in cataloguing said functionality (such that even situations that do not include biological factors of any type could also be considered situations of disability).*

It is evident that this view, which aims to be integrative and consistent in its approach to persons with disabilities, presents implicit stances about what is normal and healthy – ultimately, about an ideal of health and the functioning of a society. This has caused the ICF to be recognized internationally as a useful tool, and its use is becoming a global trend⁵⁷. However, it is necessary to take into account variables that introduce certain differentiations particular to the environment that determine disability. In this sense, the confluence of social and political acts, such as those in Colombia related to the high incidence of the phenomenon of forced displacement as a consequence of generalized violence⁵⁸, and the rates of poverty and extreme poverty (30.6% and 9.1%, respectively, in 2013)⁵⁹ are conditions that exacerbate the magnitude of disability in which childhood is particularly affected.

However, six years after the enactment of the ICF, special consideration for children and young people was made. Thus, the WHO published the International Classification of Functioning, Disability and Health: Children and Youth Version (ICF-CY, 2007). The design of this instrument was carried out to register the characteristics of childhood development and environmental influences, specifically covering the age range between 0 and 18 years. This is consistent with the guidelines in many countries and with other United Nations regulations, such as the Con-

vention on Rights of the Child adopted in 1989. Starting with this treaty, the following are recognized: demonstrations of functioning, disability, and health conditions are different from those of adults with regard to nature, intensity, and impact⁶⁰; the complexity and variability of situations of participation, which are changing and become more complex as children develop; and the changing dynamic of the environments in which children develop. Parallel to this process unfolding on the international level, in Colombia, policies were being developed and concern was growing for ways to intervene in childhood. Thus, in 2006, Law 1098 was approved, a code for childhood and adolescence that proposed a new perspective for this population.

In spite of the establishment of extensive guidelines for improving the social conditions for childhood with disabilities, the socioeconomic conditions of families with children with disabilities reinforced the situation of vulnerability in the Colombian population. According to the Registry for the Localization and Characterization of Persons with Disabilities (RLCPD by its initials in Spanish) promoted in Colombia, more than 70% of homes with one disabled family member are found in the low-low (or stratum 1) and low (or stratum 2) socioeconomic strata, while less than 1% are found in the medium-high (or stratum 5) and high (or stratum 6) socioeconomic strata⁶¹. Strata 1 and 2 include people with low resources, mostly people who benefit from governmental health subsidies. In fact, the demographic stratification data show that 63.5% of Colombian homes are in strata 1 and 2⁶². However, independent of the socio-economic stratum of the population with disabilities, the guarantee of the rights stipulated by law frequently occurs by establishing guardianship in the health entities responsible for providing those services.

The RLCPD in Colombia reports that approximately 6% of children below the age of 14 years present some type of disability (2.5% girls and 3.5% boys). It is notable that this registry is voluntary and depends on the identification of this group of people by local and/or municipal authorities and the acceptance of the situation of disability of the individual and/or the family, which entails an unequal representation of the group of persons with some condition of disability⁶¹. In fact, it is estimated that in March 2010, only 33% of all persons with disabilities were registered⁶¹.

In light of these changing dynamics, the professions of speech therapy, physical therapy, and

occupational therapy began to establish a picture of persons with disabilities from the perspective of social processes rather than individual processes, as seen in the curriculum of the physical therapy program of the University del Valle: *within an environmental focus, rehabilitation is a process in which the factors that limit good functioning or behavior of the person are corrected, modified, or adapted to facilitate his or her independence to the maximum. The improvement of the quality of life of the individuals affected by a temporary, permanent, or progressive disability is the raison d'être and the objective of rehabilitation*⁶³.

In the same way, in the syllabi for the speech therapy program of the University del Valle, disability in childhood is approached *taking as a point of reference the contributions that have been made from the discipline of speech therapy to describe and explain so-called "communication disorders," analyzed in light of the new focuses of approaching disability. With the purpose of constructing this holistic view, we look to the key aspects of the social model proposed by the WHO (ICF-2001) and ICF – children and youth, 2007. This proposal is validated as the general framework for any intervention for language and communication, which can be applied in different environments (home, daycare, school), complementing it with the specific procedures used to overcome linguistic impairment and limitations in communicative performance*⁶⁴. The purpose is to use an intervention that helps both the child and his or her family to reach proposed life goals.

Therefore, this outlines the social model of disability, which proposes that children should have the same developmental opportunities with or without disabilities, so inclusive education should be adapted to the needs of all. There is a general push towards the recognition of diversity: social, cultural, and ethnic, including the recognition of the uniqueness that each of us is special.

However, the lack of autonomy of some countries in Latin America over the enactment of these children's health policies suggests that international entities, such as the WHO, PAHO, and UNICEF, made them possible through integrated approaches, such as the currently proposed policy towards the Integrated Management of Childhood Illness (IMCI). The IMCI is centered on the general welfare of childhood and its actions are oriented towards promoting health and preventing diseases in the childhood population, which is considered vulnerable. These actions include programs such as those of

growth and development⁶⁵, which are charged with ensuring that all children reach the behaviors expected for their age according to certain predetermined developmental scales and orienting families towards seeking [re]habilitative processes that permit those who have not achieved said behaviors to approach the pre-established parameters of “normalcy” to the extent possible.

Considering this third period, we can conclude that the policies of childhood care in Colombia are fundamentally focused on social protection, which facilitates the reduction of morbidity and mortality rates, especially in the neediest populations, in terms of inequalities and resource scarcity⁶⁶. The perspectives of childhood, then, are centered on the development of a future adult who will be functional and independent and who will contribute to society.

However, in Colombia, neither the state nor the academy have approached the conceptualization of [re]habilitation, and certainly not in a way that is differentiated for childhood. This has meant that a person with disabilities is only attended to in the ways proposed by these policies. In the [re]habilitative professions, certain actions were found to be oriented towards the family and/or the school, but the focus in the legal and political realms in Colombia continues to be individualized childcare that segregates not only the child but also the family and the school from the general context. This causes the therapeutic relationship to be stressful and full of antagonistic forces, where the practices of [re]habilitation impose power regimes over bodies by prescribing the ideals of a limited body to parameters of normalcy⁶⁷.

Conclusions

The greatest challenge for [re]habilitative professionals today is to ask ourselves the following question: “What are the implications of thinking of [re]habilitating a child?” This requires us to reinvent a new form of looking at the interaction between childhood and [re]habilitation in order to have a more intersectional and integrated form of action. It would seem that the therapeutic professions are still unclear on the objective of

[re]habilitation: although we work with interactive perspectives regarding the interaction of the individual with the environment, the success of a [re]habilitation program, more than through inclusion, is achieved when the subjects are productive and independent after beginning by salvaging some abilities. In [re]habilitation programs, there is no talk of changes in the way that societies function.

In an era when, according to Jimenez⁶⁸, childhood is transformed from its daily social practices by new agents such as mass media, consumer economy, and globalization, it is necessary to rethink its [re]habilitation processes. Thus, it is no longer about a childhood limited only to family and school environments where aspects of development are questioned. In that tension between social practices is where professions such as physical therapy, speech therapy, and occupational therapy are asked to look at childhood [re]habilitative practices to determine which have been the changes ushered in by the dynamics that make up a contemporary childhood. There is recognition of a mobilization towards understanding these social processes, but the field continues to act on the individual.

Medical hegemony continues to guide the processes of [re]habilitation in a context that has been transformed, that imposes new challenges, and that requires new understandings and great conceptual and practical mobilization, such that boys and girls with disabilities are recognized as subjects of rights that they have in the present moment, transcending the view towards childhood centered on development. This makes it necessary to strengthen the dialogue between medical sciences and childhood sociology in order to transcend that view, granting children recognition from their own perspective. This is an undertaking that should definitely be studied further in future articles.

In this order of ideas, perhaps the [re]habilitative professionals in Colombia should mobilize their objects of study towards childhood socialization processes more than towards the search for ideals of perfection that sow seeds of tension in light of diversity and work to change the views of those who continue to think about differences as obstacles.

Collaborations

NA Pava-Ripoll participated in the conception, methodological organization, and writing of the article, and P Granada-Echeverry participated in the writing and critical review of the article.

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