The hospital classroom, an opportunity for educational inclusion

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Research Article

Keywords: hospital pedagogy, hospital classroom, inclusive education, educational intervention

Posted Date: June 16th, 2023

DOI: https://doi.org/10.21203/rs.3.rs-2997062/v1

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Version of Record: A version of this preprint was published at Human Arenas on September 26th, 2023. See the published version at https://doi.org/10.1007/s42087-023-00362-6.
Abstract

This article analyzes the challenges, strengths and opportunities that were recognized from the pilot phase of the Aula Lili program of the Fundación Valle del Lili. The document is the product of the systematization of the pilot phase of the program, carried out between 2021 and 2022, through the recovery of the voices of the participating actors. It was found that the educational intervention of Aula Lili has a comprehensive vision of the hospitalized child that integrates the roles of patient and student, as well as their biological, psychological and social needs. Care is proposed as the purpose of hospital pedagogy that articulates the purposes of the hospital, the school and the family as institutions interested in the development of the hospitalized child.

INTRODUCTION

Inclusive education is generally understood as the effort to develop an education program that supports the particularities and needs of each child, that is, an education that satisfactorily considers the diversity of all students (UNESCO, 2001). However, this conception is relatively recent.

In the middle of the 19th century, the importance of providing an education to all populations was agreed upon; however, this effort continued to segregate students, who were classified by their particular characteristics or deficits (Beltrán, Martínez and Vargas, 2015). The Warnock Report developed the concept of special educational needs (SEN) to emphasize the particularities that should be addressed, especially without classifying children (Warnock, 1978). From this report, the paradigm of educational integration was derived, which was also criticized for its intention to transform special education and not the educational system as a whole (Beltrán, Martínez and Vargas, 2015).

In the 1990s, the Salamanca Declaration promoted Education for All (EFA) and the inclusion of people with SEN, which promoted the paradigm of inclusive education (UNESCO, 1994). However, this declaration has also been criticized because it stipulated the historical premise that the education of a small portion of the child population, considered “marginal”, should be guaranteed through special education, which is ultimately a parallel educational system. Thus, what is usually done to guarantee EFA is the sum of two divided educational systems, something that is not authentically inclusive (Ainscow and Miles, 2008).

According to Echeita and Ainscow (2011), educational inclusion depends on the cultural particularities of each educational system; however, they point out four important aspects:

- Inclusion as a process is a permanent search for improvements to address the diversity of students.
- Inclusion seeks regular presence and constant participation and results in student learning.
- Inclusion requires the identification and elimination of barriers, such as the beliefs and attitudes of people about cultures, policies and practices that produce exclusion or school failure.
- Inclusion emphasizes those groups of students at risk of marginalization or school failure.

Hospitalized children and adolescents are a population at risk of exclusion. Since serious and chronic diseases must be treated with prolonged or frequent hospitalizations, patients are withdrawn from their social environments: school and family.
Educational care for this population began after the World War II, not only to teach them educational content but also to mitigate the psychological effects generated by hospitalization (Espitia and Barrera, 2020; Ocampo, 2019). Subsequently, international charts were approved, such as the European Charter of the Rights of Children in Hospital, the Rights and Educational Needs of Children and Adolescents with Medical or Mental Health Needs, and the Declaration of the Rights of the Hospitalized Child or Young Person in Treatment in Latin America and the Caribbean in the Field of Education, approved by the Latin American Parliament (Ocampo, 2019). In Latin America, several countries include educational care in the hospital context within their regulatory frameworks (Souza and Rolim, 2019; Salgado, 2020; Ardón, Leytón, Méndez, Monge and Valverde, 2017; Serradas, 2017).

This accompaniment to hospitalized children is known as hospital pedagogy, a comprehensive pedagogical and psycho-emotional intervention that seeks to guarantee the rights of children who are ill, improve their quality of life and respond to their biopsychosocial needs (Violant, Molina and Pastor, 2011; Bobadilla, Bori, Caedone, Ferreira, Lizasoáin, Molina and Violant, 2013). In addition, this care should consider the circumstances of the hospital stay that may affect the return of children to school and their daily lives.

According to Ocampo and Monsalve (2020), hospital pedagogy is a gap between the pedagogical and the hospital and between education and health. Although they are different fields of knowledge, they are not exclusive. However, actions taken to attend to the education and health of this hospitalized population, are not without tensions and complexities.

The psychopedagogical care proposed by hospital pedagogy is a continuous, dynamic and comprehensive process that is applicable to all people in different contexts and moments of their life cycle (Clavijo, López and Rodríguez, 2014, p. 61). Hospitalized children require affective support and decreased anxiety to overcome the negative effects of hospitalization through the use of free time and activities that promote happiness and interpersonal relationships (Clavijo, López & Rodríguez, 2014).

**Bronfenbrenner's developmental ecology**

This research is based on the contributions of Bronfenbrenner (1989) on human development, understood as “the changing conception that a person has of the ecological environment and their relationship with it, as well as their growing capacity to discover, maintain or modify its properties” (P. 29). The ecological environment is a set of structures that contain various systems at different levels in which the subject participates and transforms his or her reality.

The most immediate environment of the child, the *microsystem*, is a complex of interrelationships between close people who directly influence their development, such as the family. However, the subject participates in other environments, *mesosystems*, that directly affect their development, such as school. Then, *exosystems* exist as environments in which interactions or situations occur that can affect the immediate environment of the subject. Finally, at a broader level are *macrosystems*, a complex of systems built from ideology and social institutions common to a culture (Bronfenbrenner, 1989).

In this sense, the hospitalized child will be understood as a subject located in an ecological environment, with a microsystem, mesosystem, exosystem and macrosystem that directly or indirectly affect his or her development.
In this complex of relationships between systems are located the family, the hospital and the school, as well as the structural factors of the country's hospital pedagogy.

**Hospital classrooms in Colombia**

In Colombia, there is no public policy on psychoeducational care for hospitalized children. In the regulatory framework, there is Decree 1470 of 2013, which regulates the flexible educational model Special Academic Support (AAE), aimed at guaranteeing the school continuity of hospitalized children. In Bogotá, the District Agreement 453 of 2010 between the Secretariats of Education and Health organizes the 31 hospital classrooms of the capital city, located in 20 locations and assigned to 25 public schools (Secretariat of Education of the District, November 23, 2021, p. 3).

Cali, the main city in southwestern Colombia, does not have a legal system that organizes hospital education; however, some hospitals have responded to this demand by creating their own programs or establishing alliances with foundations that provide education to children with cancer (Gómez, 2021).

Taking into account this national scenario, it is essential to know the intervention experiences that have been developed in this field to obtain practical knowledge that will nurture other experiences in the country and the region. There are some studies on the interventions carried out by hospital classrooms in Colombia (Barbosa, Guzmán, Marroquín, Pérez and Vaca, 2014); however, it is important to continue building knowledge in this field, which is still incipient in the country.

This study explores the experience of the Fundación Valle del Lili (FVL), a hospital that in 2018, together with Universidad Icesi and other educational institutions in the city, created Aula Lili (Lili Classroom), a comprehensive psychoeducational program that seeks to do the following:

1. Contribute to the care of the physical, mental and emotional health of children and adolescents as a fundamental element of comprehensive care.
2. Provide educational and school support for the development of skills through creative and flexible strategies and resources.¹
3. Encourage play as an opportunity for freedom, autonomy and creativity in hospitalized children and adolescents.
4. Articulate, with the different actors involved, the efforts that contribute to comprehensive care processes.
5. Generate permanent reflection processes that lead to the production of knowledge (Fundación Valle del Lili, 2020, p. 10).

Aula Lili program is made up of three axes: the school education axis, focused on guaranteeing the continuity of learning, the development of competencies and the link with educational institutions; the health education axis, which promotes self-care and psychological and socioemotional health; and the playful axis, focused on autonomy, psychomotor development, imagination and creativity (see Fig. 1).

Aula Lili developed its pilot phase during September 2020 and December 2021. The program identified those hospitalized children with a high level of educational risk, that is, out of school, with socioeconomic vulnerability or with a weak support network. Subsequently, the program provided an orientation for families and contacted the school of the children's school to encourage them to continue providing educational care. However, most of
the schools did not cooperate, so the children were enrolled in new schools that assumed their educational processes. Then, Aula Lili provided support to the teachers of the schools for the construction of individual learning plans. When the children were at home, they attended their school classes through virtual means (Emergency Romote Education due to the COVID-19 pandemic), and when they were hospitalized, in addition to their virtual school classes, they were taught by hospital teachers. At the end of the process, a competency report was made by hospital teachers in order to inform the schools about the children's learning (see Fig. 2). The participating actors were as follows:

- Children: patients hospitalized in FVL participating in the Aula Lili program.
- Caregivers: mothers of the children.
- School teachers: teachers employed in the schools where the children were enrolled.
- Directives: principals and academic coordinators of the schools in which the children were enrolled.
- Hospital teacher: teachers employed by the Aula Lili in charge of providing the children with an education while they are hospitalized.
- Liaison teacher: the hospital teacher whose main task was to integrate the educational efforts of the hospital with those of the school in which the children were enrolled.
- Allied school: refers to one of the participating schools with which the Aula Lili established a closer relationship and previous agreements.

Following the fifth strategic objective of Aula Lili, the experience was systematized together with Universidad Icesi, and this article was produced to analyze the challenges, strengths and opportunities identified in the management of Aula Lili. This process allowed us to understand the voices of the different actors who participated in the piloting, as well as to obtain practical knowledge about implementation of the program that can be useful for this and for other hospital classrooms at the national and regional level.

[1] The pilot phase of the program linked the children with schools that led their educational processes. The hospital teachers provided the patients with school classes when they were in the hospital. In addition, a liaison teacher from Aula Lili advised school teachers about any adjustments to the learning plans, considering the child's health condition.

Methodology

For the development of the study, the systematization of experiences was used, an alternative research model that emerged in the 1970s thanks to the Latin American social movements and social work of the time, which questioned the traditional ways of producing knowledge (Jara, 2018). The systematization of experiences seeks to return to the intervention experiences to rescue learning or practical knowledge that can enrich future interventions. "It is a knowledge whose starting point is practice and returns to it to improve it, which raises a clear differentiation with research traditional inspired by theoretical logic" (Bermúdez, 2018, p. 149).

The subjects of the systematization of experience were those who participated in the pilot program: six children, their six main caregivers, six teachers (two hospital teachers and four school teachers) two directives and four health professionals from the hospital. Due to the diversity of the children's diagnoses (see Table 1), it was not easy to establish communication with them, which is why six image association exercises were carried out to learn about their experiences in the program. In addition to these exercises, six interviews were conducted with
their main caregivers, six interviews with their teachers and six interviews with hospital professionals, as well as three focus groups with caregivers, teachers and professionals. For the collection of information, descriptive categories corresponding to each axis of systematization were created, as well as a set of categories for the analysis of the results obtained (see Table 2).

### Table 1

*Sociodemographic characterization of the children participating in the pilot study*

<table>
<thead>
<tr>
<th>Child</th>
<th>Age (years)</th>
<th>Area of origin</th>
<th>Diagnosis</th>
<th>Socioeconomic stratum&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Ethnic self-recognition</th>
<th>College character</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lina</td>
<td>10</td>
<td>Rural</td>
<td>Down syndrome and leukemia</td>
<td>1</td>
<td>Indigenous</td>
<td>Public</td>
</tr>
<tr>
<td>Sara</td>
<td>7</td>
<td>Urban</td>
<td>Lennox-Gastaut syndrome</td>
<td>3</td>
<td>None</td>
<td>Public</td>
</tr>
<tr>
<td>Kiara</td>
<td>6</td>
<td>Rural</td>
<td>Leukemia</td>
<td>1</td>
<td>Afrodescendant</td>
<td>Public</td>
</tr>
<tr>
<td>Kiara</td>
<td>6</td>
<td>Rural</td>
<td>Leukemia</td>
<td>1</td>
<td>Afrodescendant</td>
<td>Public</td>
</tr>
<tr>
<td>David</td>
<td>7</td>
<td>Urban</td>
<td>Leukemia</td>
<td>1</td>
<td>None</td>
<td>Public</td>
</tr>
<tr>
<td>Ivan</td>
<td>7</td>
<td>Urban</td>
<td>Leukemia</td>
<td>2</td>
<td>None</td>
<td>Private</td>
</tr>
<tr>
<td>Martha</td>
<td>7</td>
<td>Rural</td>
<td>Angiodysplasia of the colon</td>
<td>1</td>
<td>None</td>
<td>Public</td>
</tr>
</tbody>
</table>

Source: Own elaboration.

<sup>a</sup> The children’s names have been changed to protect their identities.

<sup>b</sup> The socioeconomic stratum is used in Colombia for the collection of public services of real estate. However, it is also used to get an idea of the socioeconomic conditions of families. Stratum 1 is the lowest and 6 the highest.

### Table 2

*Descriptive and analytical categories by subsections of the systematization*

<table>
<thead>
<tr>
<th>Systematization axis</th>
<th>Subaxes</th>
<th>Descriptive categories</th>
<th>Analytical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive aspects of the program.</td>
<td>Benefits for children.</td>
<td>Comprehensive view of the subject</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefits for caregivers.</td>
<td>Be careful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefits for participating schools.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aspects to improve the program.</td>
<td>Relational aspects to improve.</td>
<td>Mesosystem and macrosystem</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Institutional aspects to improve.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learnings from the program.</td>
<td>Lessons from the pilot program in the context of the Covid-19 pandemic.</td>
<td>Exosystem</td>
</tr>
</tbody>
</table>

Source: Own elaboration.
RESULTS

At the beginning of this section, the strengths of the Aula Lili are presented, followed by the challenges of the classroom and the social context, specifically the educational system, and finally the opportunities of the program.

Aula Lili Strengths

Among the strengths of the Aula Lili are the integral vision of the child that underlies its interventions, which are not exhausted in educational aspects but also include emotional and social aspects of the care of the children and their caregivers; the face-to-face interventions of the hospital teachers, which were positively valued as a motivation to attend the hospital school; provision of a broader view of the educational inclusion of hospitalized children; the role of the liaison teacher in the communication between the hospital and the allied school; and finally, the adaptation of the interventions of the hospital teachers based on the resources available in the hospital.

The Aula Lili was structured with a focus on humanization and comprehensive health care, which includes a comprehensive vision of the hospitalized child. The considerations of the Aula Lili team are not limited to the child's illness but consider their motivations and interests in trying to continue socialization with their families and other children. Thus, the child is conceived as a biopsychosocial with diverse physical, emotional, affective and social needs.

The program advises caregivers on the importance of education and school continuity during hospitalization. This counseling is necessary because usually, when the pediatric patient begins hospitalization, the caregivers focus on the clinical treatment and postpone the child's other needs. The hospital teachers guide the caregivers on the alternatives available to enable access to education, in accordance with current legislation and available resources.

In addition, the program improved the mood of the children. One of the caregivers pointed out that simple activities, such as coloring, aroused the child's motivation to continue learning and reconnect with school activities. In addition, the state of mind of the caregivers was also addressed, as the hospital teachers provided them with listening spaces. The disease affects the patient as well as his or her caregiver in different ways: emotions, attitudes, coping strategies and decision making, which influence their relationship. The caregivers recognize the support provided by Aula Lili as a strength:

*I feel very grateful, the Aula Lili is love, joy, an immense accompaniment in which I have felt very supported in every way [...]. They are concerned about the education of children, and they also care about us as caregivers, that we are emotionally well* (Caregiver, interviewed on November 16, 2021).

*me siento muy agradecida, el Aula Lili es amor, alegría, un acompañamiento inmenso en que me he sentido muy apoyada en todos los sentidos [...]. Les preocupa la educación de los niños, y también se preocupan por uno, que uno emocionalmente esté bien para ellos* (Cuidadora, entrevistada el 16 de noviembre de 2021).

The children positively valued the educational interventions of the hospital teachers. These interventions became the reason why they wanted to go to the hospital. The desire to see a teacher and to do different activities made
it easier for the treatment not to be perceived as boring or routine:

Apart from the fact that we are going to receive outpatient chemotherapy, it is the emotion of seeing her, that she is going to study, to paint [...] He says, "Mommy, they love me here a lot. They love me here a lot" (Caregiver, interviewed on November 16, 2021).

Aparate de que vamos a recibir una quimioterapia ambulatoria, es la emoción de verla a ella, que va a estudiar, a pintar [...] él dice "mami, aquí me quieren mucho a mí, me aman mucho aquí" (Cuidadora, entrevistada el 16 de noviembre de 2021).

Aula Lili also broadened the schools’ understanding of the educational inclusion of the hospitalized child population. This experience familiarized regular teachers with unexplored topics such as chronic illness, death, grief, and hospital pedagogy. The liaison teacher counseled them in this regard and in understanding the purpose and meaning of education in a hospital context or in a situation of convalescence.

Faced with the institutional challenge of beginning to care for hospitalized children, the schools highlighted the role of the liaison teacher as a strength; they highlighted the importance of having a person who informs the school about the characteristics and needs of the children, who guides the teachers and who facilitates the link with the family. In addition, the liaison teacher acted as mediator when the allied school initially resisted receiving hospitalized children; she had a previous relationship with the school and its teachers, which made it easier to overcome this difficulty. The communication of Aula Lili with the allied school was closer than with the other schools in the city. Thus, the alliance between Aula Lili and one of the schools was a strength of the process.

The Aula Lili team adapted its interventions to the available resources, which is why the hospital classroom was not reduced to a static physical space since the interventions were carried out in different spaces within the hospital, such as rooms, cubicles, and corridors.

Challenges of the Aula Lili

Among the challenges of the Aula Lili are the articulation between the axes of the program; the construction of an interdisciplinary team of medical, educational and administrative professionals; the strengthening of the interventions of hospital teachers through more teaching staff and a curricular structure to guide these interventions; the communication of the hospital with the schools; and finally, other challenges associated with the Colombian education and health systems.

The main challenge that the program faces is to effectively articulate the three axes that make up the program: Playful Axis, health education and school Education. Each axis has a subprogram and a different leader. According to the initial design of the program, the intervention of a patient is expected to have a more comprehensive impact if he or she has access to the interventions of the three axes, that is, of each subprogram. The articulation had to be guaranteed by a transversal planning process in which the three subprograms aligned their psychopedagogical objectives and strategies according to the particularities of the patients. However, it was evident that this joint planning was not carried out and that the subprograms acted in a disjointed manner. In addition, the Aula Lili does not have a quantitative or qualitative description of the children who actually managed to access the three axes.
When investigating the causes of this fragmentation, the program team pointed out various reasons, such as the shortage of human resources, the lack of time due to the multiple occupations of the team members in each of the subprograms, the limitations that the COVID-19 pandemic imposed on the spaces for intervention, the lack of teamwork and the absence of an additional leader of higher rank, whose role was to articulate the three axes.

The lack of human resources was a challenge mentioned by all the subjects participating in the systematization of experiences. The caregivers expressed that the time dedicated to the children by the hospital teachers was very limited. For their part, the teachers of the allied school mentioned that although they received support from the Aula Lili team, they would have liked to receive more frequent advice, not only from the liaison teacher but also from other hospital teachers and the program’s psychologists.

more teachers are needed, like Yuliana, because it is difficult for her alone [...] they see her with David and all the children want something: ‘Can you lend me a color? Can you give me a spiderman to paint?’ [...] and the mothers are interested, because there are other mothers who have asked me (Caregiver, interviewed on November 16, 2021).

más docentes, como Yuliana, porque ella solita le queda difícil [...] la ven con David y todos los niños quieren: ‘¿me prestas un color?, ¿me regalas un hombre araña para pintar?’ [...] y las mamitas se interesan, porque hay otras mamitas que me han preguntado (Cuidadora, entrevistada el 16 de noviembre de 2021).

The allied school team did not perceive an interdisciplinary work on the part of Aula Lili. Building an interdisciplinary team is a challenge for the program, not only among the hospital teachers but also among other professionals. It was not easy for hospital teachers to meet with clinical professionals in charge of treating children to analyze specific cases, exchange key information, manage administrative processes or make decisions.

The liaison teacher pointed out that communication with the school teachers was also a challenge. Although, assertive communication with them was established in the allied school, this was not the case with the other schools, as there was silence on their part and nonfulfillment of commitments.

Another challenge for Aula Lili is the strengthening of the hospital teaching intervention. During the pilot program, efforts were focused on connecting the children with a school in hopes that the school would take charge of the educational processes. However, the success of this effort depended entirely on the responsiveness of the school and not on factors that Aula Lili could directly control.

Although the children and their caregivers positively appreciated the virtual classes at the school, the face-to-face interventions of the hospital teachers were more significant for them. In this regard, it is not only a challenge to have more hospital teachers but also to have a curricular structure to guide their work.

This finding does not mean that the challenge of improving the link with schools willing to support to children should be abandoned. To this end, the pilot project learned several fundamental lessons:

1. The importance of establishing a prior agreement with schools to facilitate interinstitutional articulation and communication.

2. The importance of adequately preparing the school and its teachers to receive and support students with medical needs, informing them of the purpose of education in this context and the expected scope.
3. More than one allied school is required due to the number of children requiring attention. In addition, allied schools must have sufficient resources and capacities to provide effective care to the population, considering that most patients cannot attend classes in person.

In this sense, the challenges of the Aula Lili go beyond its borders, since the nature of the educational inclusion of the program depends on political factors that affect hospital pedagogy, such as educational and health policies aimed at hospitalized children, as well as their articulation (Palomares, Sánchez and Garrote, 2016). Thus, there are also challenges associated with the Colombian educational system for the inclusion of children with illnesses.

The Colombian educational system must define the purpose of education for hospitalized children. The curriculum must be adapted to the particular needs of the population, as well as to the interests and motivations of children, which are fundamental in hospital pedagogy (Salgado, 2020).

In addition, the educational system must allocate resources for the education of hospitalized children. The teachers and directors of the schools pointed out that there is no such assignment, which makes it difficult for the school to assign hours to its teachers for the education of the children of Aula Lili, which is why the school declined participation in 2022.

Finally, both the education system and the health system must build agreements that allow collaborative work between both sectors. In Bogotá, the district entities have interinstitutional legal capacities (District Agreement 453, 2010; Resolution 1012, 2011) that allow an orderly operation of the hospital classrooms of the capital city (District Secretary of Education, November 23, 2021), something that does not happen in Cali.

**Aula Lili Opportunities**

From the identified challenges, opportunities arise for Aula Lili. Initially, those internal opportunities of the program are mentioned to later present those related to its environment and the current situation of the country in the face of hospital pedagogy.

One of the most relevant roles in the program is the liaison teacher, who connects the hospital with the school, the health sector and the education sector. Different actors pointed out that the liaison teacher wove the communication between both institutions, allowing the development of the interventions. This role constitutes an opportunity for the program because the articulated work between school teachers and hospital teachers is essential to provide inclusive education to hospitalized children, that is, taking into account their particularities.

The articulation that the Aula Lili established with institutions from other sector, such as schools, is also an opportunity. Although there are no regulations that order this articulation, the program built interinstitutional relationships that allowed the pilot project to be carried out.

Another of the opportunities of the Aula Lili is its reflective work, as it proposes to obtain learning from its interventions through research. Thus, this article is the product of the systematization of experiences carried out together with Universidad Icesi, from which it was possible to improve some aspects of the interventions in the hospital classroom.
Some characteristics of the environment and the moment in which the Aula Lili is developed also constitute opportunities for the program. Universidad Icesi, an allied institution of FVL, began to offer an elective in Hospital Pedagogy to its undergraduate students in the first semester of 2023. This will allow future teachers of the city to receive appropriate training on the subject and carry out their professional practices in the Aula Lili and other hospital classrooms in the city.

In addition, the mayor’s office of Cali has developed two opportunities for the socialization of hospital pedagogy experiences in the city. The First Conversation of Significant Experiences Special Academic Support and Emotional Support was held on November 26, 2021 (Martínez, 2021), and the second one a year later, which shows a growing interest in the subject on the part of the district administration. This is an opportunity for Aula Lili because the macrosystem is directing its attention to the education of hospitalized children, which can advance the organization of hospital classrooms in the city.

**Discussion and analysis**

**The child and care: An integral vision**

Given that hospital pedagogy operates between health and education, in order to achieve a comprehensive care it is necessary to create a new conception of the subject that integrates the most important aspects of both fields (subject of health, subject of education). This was a strength of Aula Lili and this comprehensiveness is highlighted by various authors (Iglesias, González, Lalueza and Esteban-Guitart, 2020; González and Esteban-Guitart, 2021; Cantor, Sánchez and López-García, 2022). It allows the efforts of the institutions in charge of ensuring the development and quality of life of hospitalized children (family, educational institution and hospital) to converge on common objectives, which allows not only the coordination of actions but also contributes to the integral well-being of children.

The construction of an integral vision recognizes the diverse needs that a hospitalized child has as a patient, child or student without fragmenting these needs; this is to recognize how the actions of all the institutions involved contribute to the development and well-being of the children. In this sense, the traditionally separate roles of patient and student overlap, given that from a traditional hospital perspective the hospitalized patient is first a patient then a student. From the traditional school perspective, the ideal student is who is in the optimal condition to attend school. Consequently, this comprehensive conception of the hospital classroom subject becomes an imperative that must challenge the traditional conception of health, moving from a limited perspective based on the absence of disease to one where health is the promotion of integral well-being. Likewise, the school needs to adopt an inclusive perspective in which diversity can be seen as an opportunity to contribute to children’s well-being rather than a difficulty to high educational standards and results.

The World Health Organization (WHO) considers that health goes beyond the absence of disease and is a complete state of psychological, physical and social well-being, both individually and collectively. However, this definition may be apolitical and ahistorical as it assumes a universal conception of "health", "well-being" and "population". A conception of health aimed at contributing to the well-being of populations that have specific needs and who develop in diverse contexts and environments, acquires a clearly political, historical and cultural dimension, since well-being and the way it is defined depend on these variables (Navarro, 1998).
In this sense, the focus of the health system is the cure of the disease, regardless of the social, political and economic context and the disease (Navarro, 1998). Thus, practices, which are structural because they order the care of all health institutions, outline a universal, ahistorical and decontextualized subject. On the other hand, the educational system, based on a concept of teaching that occurs linearly, with knowledge that is transmitted and accumulated, hides the vision of a universal, passive, heteronomous and obedient subject in the teacher-student relationship.

For the school teachers, it was initially surprising to have children with chronic diseases in their classes, participating in the classes from the hospital beds, which caused fear and uncertainty. Some indicated that they did not know of the existence of hospital pedagogy until the school's participation in this project. For their part, some hospital professionals, such as nurses and psychologists, recognized the importance of education in their pediatric patients because they closely observed the progress in their health when they participated in the educational process of Aula Lili. However, this is not fully recognized by other health professionals.

These visions are confronted with the vision of the integral subject of hospital pedagogy, as it considers not only the needs that patients experience but also those that they experience as students and individuals. Thus, Aula Lili tries to articulate and overcome the student’s vision of the educational system and the patient’s vision of the health system. This integration occurs in the classroom as an intersectional space that integrates clinical knowledge and pedagogical knowledge (Ocampo and Monsalve, 2020) to take into account the physical, emotional, educational and social needs of the child.

The family, the school and the hospital participate in this integration of the child’s needs. In this articulation, the roles assigned to the hospitalized child in each of the institutions converge as do the objectives of each one. While the hospital takes care of the children's health, the school focuses on their education and the family on parenting. The articulation of the purposes of these institutions is based on care (see Fig. 3).

For approximately 50 years, gender studies have been raising the importance of life care work in social reproduction (Carrasco, Borderías and Torns, 2011). In 1982, Carol Gilligan published *In a different voice* to explore how women have a “different” voice that integrates reason and emotion, the subject and their human relationships, a voice whose ethic is that of care, as opposed to the more traditional and masculine ethic, which she called the ethic of justice (Gilligan, 2013).

The ethics of care that Gilligan proposes is relational, integrating rationality and emotion, and gives more importance to relationships with people than to what should be, since it is not limited to conceiving laws or norms, but to their situational application. Furthermore, it focuses on close engagement with others from a particularized approach and not an abstract one such as that of the ethics of justice (Comins, 2015). The ethics of care questions the idea of the autonomous individual and energetically rejects the confinement of their values to the private sphere, since care is not a domestic but a public matter. In fact, Irene Comins (2015) is committed to a citizenship of care in which caring for others is at the center of human relationships at different scales, including the global one.

In this sense, the articulating axis of the interinstitutional relationships that participate in hospital pedagogy is care. Understood as a concern for the promotion of development and integral well-being, this element is where the main strength and character of the inclusion of the patient lies. Aula Lili and its ability to articulate the objectives of the institutions involved in the care of children implies that the institutions involved in the care and
upbringing of children move from a perspective of service providers to one in which their particular needs and capacities are considered, thanks to the adoption of a perspective of the subject of care that challenges their actions and possibilities of action. In addition, Aula Lili is a niche of care that is well valued by children, as they want to return to the hospital to learn and play, leaving the discomfort and concerns of clinical treatment in the background.

Relations between schools and hospitals during the COVID-19 pandemic

According to Bronfenbrenner (1989), the development of children is anchored to their relationship with the surrounding ecological environment; this is defined as a set of serial structures in which culture has an important role. Thus, the child is surrounded by systems represented in relationships, environments, institutions and social and cultural values. In the case of hospitalized children from Aula Lili, the ecological environment proposed by Bronfenbrenner has been redesigned in Fig. 4.

The vision of the child proposed by Bronfenbrenner is that of a subject whose development depends in an important way on his environment and the relationships he or she builds within it. In this environment, institutions establish relationships with the child, but these relationships are mediated by social and cultural values associated with the idea of equity, inclusion and justice, as well as health and education.

The indirect environment of the hospitalized child represented by the actions and policies on hospital pedagogy of government entities (exosystem) (see Fig. 4) affected the relationships between institutions (microsystem). The emergency measures adopted by the Colombian government in the face of the COVID-19 pandemic in 2020 forced educational institutions to adopt remote emergency education, as already mentioned, which meant the possibility of educational inclusion of children in the Aula Lili, which despite being widely valued by all the actors involved, did not mean lasting changes in the educational institutions. After the emergency was over, education returned to the traditional face-to-face scheme. Lasting changes imply variations not only in the individuals participating in the interaction but also in the institutions involved in the care of children with respect to, for example, the principles and values on which they base their attention in an attempt to adopt more inclusive perspectives.

From this perspective, adopting a vision of the child in an integral way is an ethical commitment of the institutions that should be reflected in their individual and collective interventions. For the adoption of this vision to be reflected in the social and cultural values that surround hospital pedagogy, it is necessary that this commitment be developed from an articulated and intersectoral work. If the institutions assume this commitment individually, it will not be enough for the educational inclusion of hospitalized children.

The articulation led by the Aula Lili questioned all the institutions involved -the school, the family and the hospital- about their conceptions of the subject, the purpose of education and the objectives to be pursued. The Aula Lili, from its hospital pedagogy, proposes the integration of these visions and objectives, leading the institutions to meet the limits of their interventions and to interact with the interventions of other institutions. Although each institution is focused on different objectives—education, upbringing and health— all of them converge in the care of children. This interstitial quality of hospital pedagogy (Ocampo and Monsalve, 2020), especially of the Aula Lili program, represents an opportunity toward the collective construction of the educational inclusion of the hospitalized child population.
From an ecological perspective of education, Iglesias, Esteban-Guitart, Puyaltó and Montserrat (2022) proposed the concept of “community socio-educational resilience (CSER)” to refer to the articulated commitment of different social, cultural and educational actors in the development of transformative educational practices that face scenarios that pose adverse and uncertain circumstances. This concept goes beyond the individual student and moves toward an integral vision that considers the environments and actors participating in the student’s educational process and includes the institutions that have an impact on the matter. To guarantee the inclusion of hospitalized children, participating institutions should develop agreements that create community socio-educational resilience.

Conclusions

Both the hospital pedagogy and the inclusive approach of Aula Lili, depend on the articulated work of the institutions that participate in it—family, hospital and school- and their visions and objectives for the children in their care.

During the pilot phase of the Aula Lili program, hospitalized children were able to participate in virtual classes because the COVID-19 pandemic forced schools to pivot from in-person to virtual classrooms instruction. During this time, hospitalized children participated in this novel educational process, building relationships with other children and their teachers. Once the public health crises had subsided, schools returned to traditional teaching methods, and hospitalized children were left out. Although the Aula Lili program tried to create the articulation of the hospital and the school, a collective commitment between the institutions is needed to allow inclusive actions in a sustainable way.

In addition, we highlight the importance of adopting a care perspective that allows the development of coordinated interventions among institutions aimed at educational inclusion, not only in terms of access to services but also the development of children. The success of these initiatives depends on the transformation of the educational system (Iglesias, González, Lalauzea and Esteban-Guitart, 2020), the health system and the linking of both of their principles in concrete policies that fully include hospitalized children.

Declarations

Ethical Approval

This research has been carried out within project No. 1807 SEAL “Systematization of the piloting experience of the Aula Lili (Lili Classroom) program of the Fundación Valle del Lili”, approved by the Biomedical Research Ethics Committee of the Fundación Valle del Lili through Act No. 20 of 2021 according to which the research did not represent any type of risk for the participants.

Competing interests

The Centro de Investigaciones Clínicas (CIC) of Fundación Valle del Lili financed the research but was not involved in its execution, analysis of results and conclusions. The participation of two researchers from Icesi University as an external entity confers greater objectivity to the study.

Authors’ contributions
Regarding the contributions of the authors, Stefany Bastidas Rivera, under the guidance of José Eduardo Sánchez, built the research project that she presented to the Fundación Valle del Lili. During the execution of the systematization of experiences, she carried out the field work; Professor José Eduardo Sánchez, Luisa Fernanda González and Yari Lorena Sierra participated in periodic meetings dedicated to the analytical construction of the data and the writing of the final report.

**Funding**

The Centro de Investigaciones Clínicas (CIC) of Fundación Valle del Lili financed the research project No. 1807 SEAL “Systematization of the piloting experience of the Aula Lili (Lili Classroom) program of the Fundación Valle del Lili” from which this article derives.

**Availability of data and materials**

The data generated in this study from the interviews and focus groups conducted is not available, as we wish to protect the identity of the participating children and adults.

**Acknowledgments**

We thank the Clinical Research Center of the Fundación Valle del Lili, Dr. Sergio Prada and other members of the group of professional research specialists for their support in the development of the project. Likewise, we want to thank the children, caregivers and teachers who participated in this study for sharing with us their experiences and perceptions of Aula Lili.

**References**


Figures

Figure 1

Psycho-pedagogical model and Structure of the Aula Lili

Source: Fundación Valle del Lili (2020).
Figure 2

Attention process in the Lili Classroom

Source: Own elaboration.
Figure 3

Notions of the subject in institutional settings

Source: Own elaboration.
Figure 4

Ecological environment of the hospitalized child

Source: Own adaptation of the scheme of Bronfenbrenner (1989).