Safeguarding, Sexual and Reproductive Health Education and First Aid for Children with Developmental Disabilities

A Handbook for Teachers

from

With Children in the

MIDDLE!

Mainstreaming and Inclusion of children with Developmental Disabilities in Learning in Ethiopia

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TABLE OF CONTENTS

Chapter 1: Safeguarding Considerations

1.1 Keeping Children with Developmental Disabilities Safe at School

There are multiple safety concerns in each child's life. Children with developmental disabilities may be more vulnerable to some. For example, some children with developmental disabilities may have reduced awareness of dangers, such as about touching hot or pointed items or electrical sockets, and may also have a reduced perception of pain that makes it harder for them to realise when they are being hurt by these objects. Others may seek out sensory sensations by placing objects in their mouths, banging their head and other potentially harmful behaviours. In these cases, protecting children from harm involves first of all supervising children to be able to intervene in case of danger, as well as two complimentary main groups of strategies: those focused on the environment and those focused on the child. There can be multiple adaptations that you can implement to make the environment safer, such as covering and hiding electrical sockets with furniture, covering walls, furniture and floor with soft furnishings, locking dangerous items and substances (e.g. medicines) away or placing them in high locations that children can't reach. Strategies focused on the child include teaching children about dangers and managing the child's behaviour. Useful strategies here can be class rules and alternative behaviours and objects to substitute unsafe behaviours and objects.

Some people with developmental disabilities may also have a tendency to run away. As well as always supervising children, managing this behaviour and teaching positive behaviour in the class, precautions can be taken to facilitate the safe return of the child in case of escape: for example, in agreement with the family, the school can provide a child information card or bracelet with emergency contact details, for the child to carry or wear at all times. However, to be able to gain some independence in their lives, the older children in primary school will need to learn about possible dangers in day to day life. Achieving this involves teaching children about crossing roads safely, recognising features of unsafe environments, being mindful of potentially harmful and abusive actions carried out by strangers or members of their circles, and about the risks of some substances, such as sigarettes, kchat and alcohol, for their health and more importantly, in the case of alcohol, for the increased vulnerability it causes. These topics can be taught through images and told and enacted social stories.

As a teacher, you may also have to pay attention to what you do, so that you avoid putting a child at risk, for your own sake and theirs. Firstly, this includes avoiding corporal

punishment. We also recommend you do not administer medications as a teacher: this is because if a caregiver gives you a medicine to give a child, you cannot be sure of what the medicine really is or if it was prescribed. It is best to also avoid giving sweets or foods unless agreed with caregivers.

1.2 Recognising and Reporting Harmful Situations

Safeguarding also importantly involves recognising existing situations that harm the child or put them in danger, both at school and out, and acting upon them in the most appropriate way. Some key situations are bullying, physical abuse, emotional abuse, sexual abuse, and neglect. You may observe some of these directly, for example a child repeatedly being bullied by peers at school, or punished by a colleague with violence. One important rule to avoid situations like this is that one child and one teacher should never be alone. There should always be at least one other child or one other teacher with them. Other times, especially for situations happening at home or in the community, you will need to recognise the signs, so it is important that you know these signs and that you often monitor children who may be at risk. For children with developmental disabilities, we recommend that you regularly check (at least once a week, possibly more often) whether they have any bruises or other signs of abuse. It is also important that children feel safe with you and that they can trust you, so that they might be comfortable reporting these things to you.

Going into a bit more detail on some of these situations, neglect is when a child's family does not meet the basic physical and psychological needs of a child within their financial possibilities: in this case, you may for example notice the child being dirty, wearing dirty clothes, or clothes that are in a much worse state compared to any siblings, or a deterioration of the child's health and development. Emotional abuse happens when people say or behave in a way that conveys to the child that he/she is inadequate, unloved, worthless. Bullying, isolating, criticizing, terrorizing, ignoring and shaming are types of emotional abuse. Physical abuse is any kind of violence, that may be happening at school, in the community or at home, usually repeatedly by people within the child's circle. Signs that physical abuse may be occurring include unexplained broken bones, bruises, bites, burns, scratches and other injuries. If an adult is carrying out abuse, they may appear overly severe and harsh when with the child. Sexual abuse is defined as any act that forces or entices a child or young person to participate in sexual activities. It can take place even if the child does not understand what is happening and there may be no

violence involved (and subsequently no bruises, scratches, etc.). It can take many forms including rape, commercial sexual exploitation and domestic sexual abuse. Often, sexual abuse involves someone the child knows and that tells the child to keep the relationship a secret. They may be threatened with something bad happening if they tell anyone about the abuse. Physical signs that may indicate sexual abuse include difficulty walking or sitting down. The child may also be talking about sex, or displaying unexpected sexual knowledge for their age, or may unexplainedly become pregnant or get a sexually transmitted disease. In the case of both physical and sexual abuse, you may also notice that the child seems scared of an adult, or indirectly scared or unwilling to go to a specific location, or they may be overly watchful or flinch when touched. But in the case of sexual abuse the child may also seem unexpectedly attached to the adult who is abusing him/her. Girls may be more at risk of sexual abuse, but it is important to be mindful of possible signs of sexual abuse also in boys.

When reasonably suspecting a situation that is harmful or potentially harmful for a child, it is important that you act upon it by reporting your suspects, even if you are not sure: designated people will take care of verifying the concerns and choose the best course of action to protect the child. Your school has a system for reporting concerns: ask about this if you are not sure. Even if you feel that the children in your class can trust you, it is important that you make them all aware of the reporting system too, as they may feel more comfortable referring to this system rather than reporting their harmful situations to you.

Chapter 2. Teaching Sexual and Reproductive Health (SRH)

2.1 Introduction

As other children, children with developmental disabilities are vulnerable to abuse, and they may also be at increased risk due to their difficulty in social communication and in interpreting other people's emotions and behaviours, as well as at times due to being more socially isolating and desiring to be socially accepted. Moreover, puberty can be a stressful and confusing time for adolescents with developmental disabilities and cause increased vulnerability. Older children may also take risks in sexual intercourse. It is important to note that parents should be the primary source of SRH education or information for their adolescents. At the same time, school provides important opportunities for teaching adolescents (from 10 years old) about these topics, and children with developmental disabilities should not be left out from this training, to protect them from abuse and ensure

that their rights are met. International human rights documents acknowledge that all people have the right to receive knowledge about sexuality in a way that they can understand and obtain the highest standard of sexual health care available to them. They also have the right to love and be loved, choose a partner, marry, have children, express their sexuality in ways that are socially appropriate, and to pursue a satisfying, safe and pleasurable sexual life. However, some considerations and adaptations may be needed to deliver appropriate SRH training to children with developmental disabilities.

The most important thing to know how to adapt this training will be knowing the child and his/her unique world, along with sexual feeling and its management from their perspective. However, there are some general needs that you can be mindful of and strategies that you can learn.

2.2 Teaching Children about Their Bodies and Personal Hygiene

First, adolescents with developmental disabilities may have fragmented understanding of their physical identity. They may need to be taught about their body parts, and that these parts belong to them and are part of them. Teaching a child to label body parts correctly will support them in learning other important concepts such as hygiene, health, toileting, reproduction and safety skill. Start teaching from their own basic / non-private body parts, such as ears, nose, hands, and help them learn that body parts have functions (for example the five senses). You can do this with images (or, even better, 3D models) of both females and males and by telling and demonstrating the specific body parts so that they are able to demonstrate their own body parts. Then, teach them about the external genitalia and ask to locate the breast, vagina or penis. Identify external genitalia using male and female 3D models. You will then be able to proceed to help them learn about the functions and discharges of reproductive organs, as well as teaching them about sexual identity and helping them identify their own sex and that of other people. You can do this once again with 3D models, by teaching body parts that are only found on males, for example mustache, chest hair, penis, and those that are only found on females, such as breast, wide hips and vagina.

As well as for teaching about SRH and interpersonal behaviour, teaching parts of the body can be useful to remind children about personal hygiene. This does not necessarily mean teaching them how to clean their hands, teeth and other daily living skills. It is about reminding children that personal hygiene is important and they should regularly clean their teeth, wash their hands, face, hair and bodies and wear clean clothes. Many youths with

developmental disabilities, even those who may live quite independently, with their own jobs and families, report that they still need visual, tactile and/or verbal reminding to look after themselves. SHR education is also a good time to teach adolescent girls about menstrual hygiene: from preparing pre-puberty girls for what periods look like (for example using red coloured fluids), to teaching them to wash and keep menstrual hygiene before and during periods, and using sanitary pads.

2.3 Teaching Children about Private Parts and Behaviours, Abuse and Sex

After teaching children with developmental disabilities about parts of their body, you will also be able to teach them which ones are most private. All adolescents need to learn the difference between what is public and what is private. This is not limited to parts of the body, but also places, conversations, behaviours and even online communication. However, some adolescents with developmental disabilities may have a distorted understanding of privacy and they may assume that their bodies, spaces, and lives are open to the public. When teaching private parts of the body, it is important not to teach that only private parts should not be touched and also not to refer to the rest of the body as "public": all their body is owned by them and is not open to the public: this may seem obvious to you, but they may need to be taught about it. Private body parts include the penis, vagina, mouth, buttocks and breasts. Private places and spaces are places that other people cannot access or simply enter to see you. Public places, on the other hand, are places that anyone can access, and where therefore they should be more mindful of their behaviours and of their private body parts. For example, children with developmental disabilities may need to be taught when and where they can be naked in their underwear and who can see them in their underwear and how they should properly act in private and public places. Useful strategies to teach these concepts include told and enacted instructional stories and role plays.

After teaching adolescents about private and public, you will be able to help them learn about appropriate interpersonal behaviour, and protecting themselves from abuse. Many adolescents with developmental disabilities who have not received SRH education in areas such as boundaries, relationships, appropriate touch, communicating their emotions and recognizing other people’s emotions and intentions, may struggle to recognise a risk of abuse or they may themselves unknowingly behave in ways that are considered inappropriate and therefore be vulnerable to the accusation of harassment, stalking, or abuse. It is therefore important to teach them about other people’s emotions and

intentions, personal boundaries, the dangers posed by people who do not respect those boundaries, and the differences between stranger and trusted circles. For any children, stranger and trusted circle danger isn't something you can teach in just one day: it something to consistently remind children of, and that especially parents should regularly teach their children when they are out with them. For children with developmental disabilities, this process may be even harder, because of the social and communication difficulties these kids face, specifically their difficulty to understand that a person may have different intentions from the ones that they are making explicit. This is not limited to abuse: for example, if a person offers them candy, it may be difficult for them to understand that they may have malicious intentions. In SRH education, teachers can teach adolescents about the dangers that can be posed by both strangers and trusted circles, as well as explaining children that they should report abuse, even when done by a trusted person that tells them to keep it a secret, and how to report it safely.

As mentioned at the beginning, it’s important that you know the child and their relationship with their body and their sexuality. Depending on the pupil’s age and your understanding of their sexual drive, you may consider relevant to include sexual intercourse in the SRH education you give the pupil. When doing so, it is key that you have a positive attitude towards the pupil and recognise that people with disabilities have the same right to romantic and sexual relationships as anyone else. Using the same strategies presented above (visuals, instructional stories, identifying intercourse as a private behaviour) you can present any relevant content that you would present to other pupils, such as the importance of protected sex.

Chapter 3. Key First-Aid Principles

3.1 Introduction

Here follows a brief introduction to first-aid relevant to developmental disabilities. First aid is the immediate care given to a person who has been injured or suddenly taken ill. This will be helpful so that everybody can provide emergency support as soon as needed. However, there should always be at least one health professional or designated first-aid trained teacher or member of staff at the school. The first step in providing first aid is to assess the situation and the child's condition. If the child is conscious, ask them what happened and where it hurts. If the child is not responsive, check their breathing and pulse. In case of emergency, as well as providing initial first-aid, you should make sure

that you immediately prompt a specific child in the class to go call the designated member of staff or someone that can help taking the child to a health facility, and another to use your phone to call an ambulance (providing them with the number). It is always best to call them by name, rather than making a general request. It is even better if a few children in the class are designated and trained for these two help-seeking tasks.

3.2 Nosebleed and Injuries

Common incidents in all children may be nosebleed and injuries. If a child has a nosebleed, have them sit upright and lean forward slightly, pinch the soft part of their nose with a tissue or cloth for 10-15 minutes, and apply ice or something cold to the bridge of their nose to help stop the bleeding. To provide initial first aid training for injuries, first assess the situation and severity of the injury. For minor injuries, such as cuts or scrapes, clean the wound with soap and water and cover with a clean bandage or dressing. For wounds that involve bleeding, apply pressure to the wound until the bleeding stops. If the bleeding is heavy, do not wash the wound, and if there is an object in the wound, do not remove it: in both cases, call emergency medical support. Keep burns them under cold running water, but not ice or other cold objects, for at least 20 minutes. For sprains, bumps, and similar injuries with no open wounds, apply ice (wrapped in clothing), cold water or something cold for up to 20 minutes. Keep the injured area elevated to improve blood flow and promote healing. Apply ice also for broken or possibly broken bones, while also ensuring you call for help and do not move the child unless absolutely necessary. After a head injury, similarly apply something cold for up to 20 minutes, and it is important to monitor the child for any signs of concussion, such as headache, dizziness, vomiting, or confusion: seek medical attention if any of these symptoms occur.

3.3 Fainting

Other emergencies may involve fainting, chocking, allergic and asthma attacks, and seizures. If a child faints and/or is non-responsive, first check for breathing. If the child is breathing normally, the first step is to lay him/her down on their back and elevate their legs above the heart level and loosen any tight clothing. This can help improve blood flow to the brain and prevent the child from injuring themselves if they collapse. Ensure that there is enough fresh air in the room. If the child regains consciousness within a few seconds, offer them water and wait for a few minutes to make sure they are fully alert and oriented. If the child remains unconscious for more than a few seconds, call emergency medical help immediately. However, if the child is non-responsive and has difficulty breathing or is

not breathing, call emergency help immediately. If the child is breathing with difficulty, lay him/her on the side and tilt their head back to open their airways. Loosen any tight clothing and ensure that there is enough fresh air in the room. If a child is non-responsive and not breathing, lay the child on the back, give five rescue breaths, 30 chest compressions, and then cycles of 2 rescue breaths and 30 chest compressions until help arrives. For rescue breaths, tilt their head back, seal your mouth over the child's mouth, pinch his/her nose and blow into the child's mouth. For chest compressions, push firmly in the middle of the child's chest with one hand so the chest goes inward, then release, as demonstrated: you will be acting as the heart, helping keep the vital organs alive, including the brain. If you are small or the child is large, you may need to use two hands.

3.4 Chocking

Choking is a common emergency in children, and may be more likely to happen to some children with developmental disabilities who often put small objects in their mouths. If a child is choking, it is important to call help and act quickly and effectively to help them clear their airway. Don't give the child food or drinks. If the child is coughing, encourage them to continue coughing to try and dislodge the object and hit them firmly on their back between the shoulder blades up to five times. If the child cannot cough or breathe, following the five strikes in the back, perform the Heimlich maneuver. To perform the Heimlich maneuver on a child, stand behind them and place one fist just above their belly button. Use your other hand to grasp your fist and press inward and upward with a quick, forceful thrust. Repeat this maneuver until the object is dislodged or until medical help arrives. If the object is dislodged but has not come out of the mouth, the child will need medical attention. If the child becomes unconscious and stops breathing, start the cycles of rescue breaths and compressions demonstrated earlier.

3.5 Asthma Attacks and Allergic Reactions

Children may also have asthma attacks and allergic reactions. In the case of an asthma attack that lasts more of a few minutes, or an allergic reaction with swelling and difficulty breathing, call help immediately and reassure the child while waiting for help and have them sit upright. For asthma, if the child has a quick-relief inhaler make him/her use it. For severe allergic reactions, if the child has a known allergy and carries and auto-injector, administer the injection into the child's outer thigh and hold for several seconds before removing. Check the expiration date and instructions on the auto-injector beforehand. Stay with the child and monitor their breathing and response until medical help arrives. If the

child becomes unconscious and stops breathing, start the cycles of rescue breaths and compressions demonstrated earlier.

3.6 Seizures

Some children with a condition called epilepsy may have seizures, that involve collapsing and being stiffen or making sudden jerking movements, and at times having froth around their mouth. Seizures are not contagious. If a child is having a seizure, make sure they are in a safe place, where they cannot harm themselves, and protect their heads. Do not leave them alone and do not put anything in the mouth of a child who is convulsing. Do not light a match and make the child smell the smoke. Do not restrain or try to stop the child's movements during a seizure, as this can cause injury. Instead, gently guide them away from any objects that could cause harm, such as furniture or sharp objects. If the child has a known epilepsy diagnosis and the seizure lasts less than five minutes, you can stay with the child and comfort them until the seizure stops. If it’s the first seizure or it lasts over five minutes, call emergency medical help. After the seizure, turn the child onto their side and tilt their head back to help clear their airway and prevent choking. Do not give the child food or drinks until they are fully conscious and able to swallow safely.

3.7 Panic Attacks

Some children with anxiety, an emotional disorder that we have mentioned in Session 5 and that may be frequent in children with developmental disabilities, may have panic attacks: a few minutes when the child may have intense fear and feel a fast heart rate and/or difficulty breathing. If this happens for the first time, call emergency help, as it may be a physical emergency rather than a panic attack. If the child is known to have panic attacks, have them sit or lie down and make sure people do not surround them closely. Reassure them and guide them through slow deep breaths.

Additional Resources

You can read or hear more about these topics in:

Nia Foundation (2022). Quick Reference Booklet for Parents, Teachers/Caregivers, and Professionals Working with Adolescent/youth with Autism and related developmental disorders. Nia Foundation

British Red Cross Society. Learn First Aid Skills for Babies and Children. British Red Cross. https://www.redcross.org.uk/first-aid/learn-first-aid-for-babies-and-children

Juntos (n.d.) Seizures. Ubuntu hub. https://www.youtube.com/watch?v=Kf6Gtj-KmRk