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HEALTH AND SAFETY IN INCLUSIVE SCHOOLS: A PUBLIC–PRIVATE COMPARISON BASED ON UNICEF'S INCLUSIVE EDUCATION CRITERIA

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Abstract
Safe, healthy and inclusive school environments have been found to be a pre-condition to fair education systems. Based on this, this quantitative study analyzed health and safety practice in the public and private inclusive institutions, with pointers following the criteria of Standards & Indicators of Inclusive Education prescribed by the UNICEF. The conformity rates were summarized with descriptive statistics and the differences between the institutions of the public and the private ones were tested with the help of chi-square tests. The results show that the two sectors recorded high levels of compliance on some of the structural and policy related indicators such as sanitation management, safety orientation, non-discriminatory rules, and secured school environments. Nevertheless, private institutions at all times fared better than the public institutions in terms of emergency preparedness measures such as the availability of first aid facilities, trained staff and availability of medical support. It is also important to note that in both sectors, the compliance was low on the indicators that touch on nutrition, such as the provision of meals, trained kitchen personnel, and food storage facilities, which implies that systemic weaknesses are common. The article concludes that despite the mode of primary safety precaution being mostly accomplished, nutrition service and emergency health preparedness have huge gaps, especially by state institutions. To promote safe and inclusive learning and education environments in accordance with international education and child well-being practices, it is crucial to strengthen integrated school health policies, resources allocation, and capacity of institutions.

Introduction

In Pakistan, initiatives of inclusive education have increased both in the state and non-state sectors; however, there is still uneven implementation. Research shows that it is typical that private institutions have comparatively high-quality resources and infrastructure, and public schools must face institutional limitations of the funding, maintenance, and service provision (Rafique, 2021). The regional analysis by UNICEF on the topic of disability-inclusive education in Pakistan shows that school environment and infrastructure, such as health and safety measures, are one of the weakest but most critical areas of meaningful inclusion (UNICEF, 2021). However, there is little systematic empirical evidence comparing health and safety in both private and public inclusive schools that is juxtaposed to criterion international framework.

In the study, to assess the application of health and safety standards such as WASH facilities, access and safe mobility, environmental safety, emergency preparedness, and institutional support mechanisms in the two sectors, the study focuses on exemplary inclusive institutions around the country. It is the long-term goal to develop evidence-based knowledge that may guide policymakers, school leaders, as well as other stakeholders committed to enhancing inclusive education not only in the context of accessibility and teaching, but also safe, healthy, and dignified learning experiences that all learners may enjoy. (Kifayat Ullah et al., 2024; Khan et al., 2025).

Due to this gap, the current paper discusses the issue of health and safety in inclusive schools based on a comparative framework involving the public and the private based on the Universal Children Fund guidelines on the matter of inclusive education. The study evaluates the operationalization of the health and safety standards of the two sectors by considering the model inclusive institutions all over Pakistan, including WASH amenities, access and secure movement, environmental safety, and preparedness. This comparison project aims at providing evidence-based suggestions to the policymakers, school administrators, and interested parties willing to strengthen inclusive educational experiences not only in access, but also about safe, sound, and respectful learning experiences among all learners.

Statement Problem

To carry out comparative study on Health and Safety in Public and Private Inclusive Education Institutions UNICEF Standards and Indicators for Inclusive Education.

Objectives

The objective of the study was:

1. To compare health and safety implementation in inclusive education across public and private model institutions in Pakistan, using UNICEF criteria.

Null Hypotheses

Ho1: There is no significant difference regarding Health and Safety provisions between Public and Private Inclusive Education Institutions in Pakistan.

Sub Null Hypothesis:

$H_0$1.1: There is no significant difference between public and private institutions in providing nutrition programs (two meals per day).

$H_0$1.2: There is no significant difference between public and private institutions in the availability of a trained cook.

$H_0$1.3: There is no significant difference between public and private institutions in the availability of a standard kitchen.

$H_0$1.4: There is no significant difference between public and private institutions in providing proper food storage facilities.

$H_0$1.5: There is no significant difference between public and private institutions in garden availability within the institution.

$H_0$1.6: There is no significant difference between public and private institutions in providing clean water for drinking and cooking.

$H_0$1.7: The null hypothesis argues that there is no statistically significant difference in the availability of clean, safe, and universally accessible toilet facilities in the operations of the public and the private educational institutions.

$H_0$1.8: The null hypothesis state that there is no statistically significant difference between the supply of handwashing facilities with soap next to their toilets in public and private institutions.

$H_0$1.9: The null assumption is that there is no substantial difference between the public and the private institutions in terms of the sufficiency of the toilet paper offered.

$H_0$1.10: The null hypothesis argues that there are no critical differences existing between the provision of sanitary towels during emergency situations in both the public and the private institutions.

$H_0$1.11: The null hypothesis is that the difference in garbage management practices implemented between the public and the private institutions is not statistically measurable.

$H_0$1.12: The null hypothesis asserts that there is no substantial difference between the two, the public and the private institutions regarding entry point security using the security guards.

$H_0$1.13: The null hypothesis holds that there is no statistically significant difference between the provision of fire extinguishers and first-aid kits to public and private institutions.

$H_0$1.14: The null hypothesis is that there are no significant differences between the public and the private institutions in the construction of separate fences around the transformers and swimming pools.

$H_0$1.15: The null hypothesis argues that there is no significant difference between the measures implemented in the public and the private institutions in terms of put into effect policies that oblige learners to visit workshops, laboratories, and gardens only when they are supervised by their teachers.

$H_0$1.16: The null hypothesis states that there is no statistically significant difference between public and private institutions in orienting the learners on safety procedures when they join the institution.

$H_0$1.17: The null hypothesis will assert that there is no statistically significant difference between the two institutions (public and private) in the preservation of a dedicated first-aid room where one can undertake immediate attention after trauma, illness or injury.

$H_0$1.18: There is no significant difference between public and private institutions in training learners and school staff members in first-aid practices.

$H_0$1.19: There is no significant difference between public and private institutions in having a first-aid kit that is well equipped with bandages and medication.

$H_0$1.20: There is no significant difference between public and private institutions in having adequate drainage systems for toilets, laboratories, and kitchens.

$H_0$1.21: There is no significant difference between public and private institutions in providing garbage bins in strategic areas around the institution.

$H_0$1.22: There is no significant difference between public and private institutions in covering drainage holes and canals.

$H_0$1.23: There is no significant difference between public and private institutions in locating parking areas away from classrooms and playgrounds.

$H_0$1.24: There is no significant difference between public and private institutions in having well-defined rules for health, child protection, and psychosocial support.

$H_0$1.25: There is no significant difference between public and private institutions in whether institution rules discriminate in terms of race, gender, culture, or religious beliefs.

$H_0$1.26: There is no significant difference between public and private institutions in being periodically visited by professionals on health, violence, bullying, and discrimination.

$H_0$1.27: There is no significant difference between public and private institutions in training disciplinary committees and career-guidance teams on issues of violence, bullying, and discrimination.

$H_0$1.28: There is no significant difference between public and private institutions in assigning administrators, teachers, and community members duties to help learners who are victims of abuse, bullying, or discrimination.

$H_0$1.29: There is no significant difference between public and private institutions in having contact with professionals who provide support to learners.

$H_0$1.30: There is no significant difference between public and private institutions in medical teams visiting the institution according to an established schedule.

RESEARCH METHODOLOGY

The purpose of the study was to investigate the compliance of Health & Safety as prescribed by UNICEF Standards and Indicators in Inclusive Education Institutions in Pakistan. Survey Research Design was used. Questionnaire was Close Ended, which was prepared based on Standards and Indicators of Inclusive Education provided by UNICEF. This questionnaire was responded by the Principals of Inclusive Education Institutions which responded to Three Point Likert Scale.

Population: Population of the study consisted of all Public and Private Institutions throughout Pakistan who claim that they provide Inclusive Education to their students. There are four provinces in Pakistan, Punjab, Sindh, Khyber Pakhtunkhwa, and Baluchistan.

Sample: There are four provinces in Pakistan, namely, Punjab, Sindh and KP and Baluchistan. The entire population was taken as sample of the study. There are only 55 Institutions in our population. For smaller populations, say, N = 100 or fewer, there is little point in sampling, surveying the entire population. (Gay, Mills, & Airasian, 2012)

Research Instrument: A close ended questionnaire was prepared based on Standards and Indicators as given by UNICEF for Inclusive Education. The questionnaire was requested to be answered by Heads of Inclusive Education Institutions on Three - Point Likert Scale i.e., Yes, No, and Un-Decided.

Validity and Reliability of the Instrument

Reliability of questionnaires was checked through Cronbach's alpha using SPSS v30. Item-level CVI (I-CVI) values ranged from 0.80 to 0.90, indicating that at least 9 out of 10 experts agreed on the relevance of each item, while the scale-level CVI (S-CVI/Ave) was 0.95, demonstrating excellent overall content validity. (Lynn, 1986; Polit & Beck, 2006). Reliability analysis using SPSS v30 overall Cronbach's alpha coefficient of 0.91, extremely high internal consistency. (DeVellis, 2017; Tavakol & Dennick, 2011).

Data Analysis: Chi Square Test of Independence was used for comparison as no response was recorded in Undecided so we exempted that from table.

Analysis And Interpretation of Data

Ho1: There is no significant difference in the implementation of Health & Safety between Public and Private Inclusive Education Institutions in Pakistan.

Table 1: Comparison of Compliance level of Health & Safety in Public and Private Institutions in Pakistan (α = 0.05, df = 1)

SN	Indicators	Institution & N	Yes (%)	No (%)	χ^2	p-value
1	Nutrition program (two meals per day)	Public (N=18)	2.0 11.1%	16.0 88.9%	0.001	0.973
		Private (N=37)	4.0 10.8%	33.0 89.2%		
2	Trained cook available	Public (N=18)	3.0 16.7%	15.0 83.3%	0.097	0.756
		Private (N=37)	5.0 13.5%	32.0 86.5%		
3	Standard kitchen available	Public (N=18)	3.0 16.7%	15.0 83.3%	0.097	0.756
		Private (N=37)	5.0 13.5%	32.0 86.5%		
4	Proper food storage facilities	Public (N=18)	5.0 27.8%	13.0 72.2%	0.254	0.614

		Private (N=37)	8.0 21.6%	29.0 78.4%		
5	Garden availability in institution	Public (N=18)	5.0 27.8%	13.0 72.2%	0.254	0.614
		Private (N=37)	8.0 21.6%	29.0 78.4%		
6	Clean water for drinking & cooking	Public (N=18)	13.0 72.2%	5.0 27.8%	1.012	0.315
		Private (N=37)	31.0 83.8%	6.0 16.2%		
7	Clean, safe and accessible toilets	Public (N=18)	14.0 77.8%	4.0 22.2%	0.003	0.960
		Private (N=37)	29.0 78.4%	8.0 21.6%		
8	Handwashing with soap near toilets	Public (N=18)	14.0 77.8%	4.0 22.2%	0.003	0.960
		Private (N=37)	29.0 78.4%	8.0 21.6%		
9	Sufficient toilet paper available	Public (N=18)	2.0 11.1%	16.0 88.9%	0.001	0.973
		Private (N=37)	4.0 10.8%	33.0 89.2%		
10	Sanitary towels for emergencies	Public (N=18)	5.0 27.8%	13.0 72.2%	0.254	0.614
		Private (N=37)	8.0 21.6%	29.0 78.4%		
11	Garbage management practices	Public (N=18)	17.0 94.4%	1.0 5.6%	0.001	0.982
		Private (N=37)	35.0 94.6%	2.0 5.4%		
12	Entry points secured with guards	Public (N=18)	15.0 83.3%	3.0 16.7%	1.858	0.173
		Private (N=37)	35.0 94.6%	2.0 5.4%		
13	Fire extinguishers & first aid kits	Public (N=18)	16.0 88.9%	2.0 11.1%	0.132	0.716
		Private (N=37)	34.0 91.9%	3.0 8.1%		
14	Separate fences for transformers & pools	Public (N=18)	14.0 77.8%	4.0 22.2%	0.671	0.413
		Private (N=37)	32.0 86.5%	5.0 13.5%		
15	Rules for supervised visits to labs/gardens	Public (N=18)	15.0 83.3%	3.0 16.7%	0.097	0.756
		Private (N=37)	32.0 86.5%	5.0 13.5%		
16	Learners oriented on safety on admission	Public (N=18)	17.0 94.4%	1.0 5.6%	0.117	0.732
		Private (N=37)	34.0 91.9%	3.0 8.1%		

17	First aid room available	Public (N=18)	9.0	9.0		
			50.0%	50.0%	10.303	0.001
		Private (N=37)	33.0	4.0		
			89.2%	10.8%		
18	Staff & learners trained in first aid	Public (N=18)	10.0	8.0		
			55.6%	44.4%	9.992	0.002
		Private (N=37)	34.0	3.0		
			91.9%	8.1%		
19	First-aid kit well equipped	Public (N=18)	10.0	8.0		
			55.6%	44.4%	9.992	0.002
		Private (N=37)	34.0	3.0		
			91.9%	8.1%		
20	Adequate drainage functioning	Public (N=18)	9.0	9.0		
			50.0%	50.0%	4.566	0.033
		Private (N=37)	29.0	8.0		
			78.4%	21.6%		
21	Garbage bins in strategic areas	Public (N=18)	10.0	8.0		
			55.6%	44.4%	5.085	0.024
		Private (N=37)	31.0	6.0		
			83.8%	16.2%		
22	Drainage holes & canals covered	Public (N=18)	15.0	3.0		
			83.3%	16.7%	1.858	0.173
		Private (N=37)	35.0	2.0		
			94.6%	5.4%		
23	Parking away from classrooms/playgrounds	Public (N=18)	17.0	1.0		
			94.4%	5.6%	0.117	0.732
		Private (N=37)	34.0	3.0		
			91.9%	8.1%		
24	Rules on health, protection & psychosocial support	Public (N=18)	13.0	5.0		
			72.2%	27.8%	1.012	0.315
		Private (N=37)	31.0	6.0		
			83.8%	16.2%		
25	Non-discriminatory institutional rules	Public (N=18)	17.0	1.0		
			94.4%	5.6%	0.117	0.732
		Private (N=37)	34.0	3.0		
			91.9%	8.1%		
26	Visited by professionals on bullying, health	Public (N=18)	14.0	4.0		
			77.8%	22.2%	0.003	0.960
		Private (N=37)	29.0	8.0		
			78.4%	21.6%		
27	Disciplinary team trained on issues	Public (N=18)	10.0	8.0		
			55.6%	44.4%	3.978	0.046
		Private (N=37)	30.0	7.0		
			81.1%	18.9%		
28	Admins/teachers/community support learners	Public (N=18)	10.0	8.0		
			55.6%	44.4%	3.978	0.046
		Private (N=37)	30.0	7.0		
			81.1%	18.9%		
29	Institution contacts professionals for support	Public (N=18)	15.0	3.0		
			83.3%	16.7%	1.858	0.173
		Private (N=37)	35.0	2.0		

			94.6%	5.4%		
30	Medical teams available for emergencies	Public (N=18)	9.0	9.0	10.303	0.001
			50.0%	50.0%		
		Private (N=37)	33.0	4.0		
			89.2%	10.8%		

Indicator 1: Nutrition program (two meals per day): The results show that 11.1% of public institutions and 10.8% of private institutions reported providing two meals per day, while most institutions in both sectors reported non-compliance. Chi-square showed no statistically significant difference in public and private institutions ($\chi^2 = 0.001$, $p = 0.973$). This suggests that nutrition programs are similarly inadequate in both sectors; therefore, the null hypothesis was accepted.

Indicator 2: Availability of the trained cook: In 16.7 percent of the public institutions and 13.5 percent of the private institutions, a trained cook was reported; the rest of the institutions did not have such a person. The chi-square test did not show statistically significance between two institution types ($\chi^2 = 0.097$, $p = 0.756$). Thus, the null hypothesis of equal proportions was accepted.

Standard kitchen availability Indicator 3: It was found that public and private institutions had standard kitchen facilities in 16.7 and 13.5 percent, respectively. The chi-square test showed that there was no statistically significant difference between ($\chi^2 = 0.097$ $p = 0.756$) and therefore rejected the null hypothesis of the similarity of the conditions in various sectors.

Indicator 4: The right food storage facilities: 27.8 and 21.6% of the public and private institutions reported proper food storage respectively. The chi square test value ($\chi^2 = 0.254$, $p = 0.614$) showed no difference at a significant level between the two kinds of institutions and accordingly the null hypothesis was accepted.

Indicator 5: Availability of gardens in the institution: One out of every two institutions (public and private) reported being available of garden. The chi-square value ($\chi^2 = 0.254$, $p = 0.614$) proved not to be statistically significant and caused the null hypothesis to be accepted.

Indicators 6: Portable drinking and cooking water: Amongst the public institutions, 72.2% had clean water and 83.8% had clean water in the private institutions. Inasmuch as the availability was greater in the case of private institutions, the disparity was not significant ($\chi^2 = 1.012$, $p = 0.315$). Thus, the null hypothesis was admitted.

Indicator 7: Accessible, clean and safe toilets: Of the public institutions, 77.8 and that of the private institutions 78.4 reported having clean and pleasant toilets. Results of the chi-square test ($\chi^2 = 0.003$, $p = 0.960$) showed no significant difference in the two sample groups and null hypothesis was accepted.

Indicator 8: Toilet handwashing with soap: On 77.8% and 78.4% of the institutions; both the public and the non-public, handwashing facilities with soap were available close to the toilets. The chi idea test ($\chi^2 = 0.003$ 0.960) revealed that there was not any significant difference hence adding weight to the null hypothesis.

Indicator 9: Availability of toilet paper: Only 11.1% of public institutions and 10.8% of private institutions reported sufficient toilet paper availability. The chi-square test showed no statistically significant difference ($\chi^2 = 0.001$, $p = 0.973$). Hence, the null hypothesis was accepted.

Indicator 10: Sanitary towels for emergencies: Sanitary towels for emergencies were available in 27.8% of public institutions and 21.6% of private institutions. The chi-square analysis indicated no significant difference ($\chi^2 = 0.254$, $p = 0.614$). The null hypothesis was accepted.

Indicator 11: Garbage management practices: Garbage management practices were reported by 94.4% of public institutions and 94.6% of private institutions. The chi-square test

indicated no significant difference ($\chi^2 = 0.001$, $p = 0.982$). Thus, the null hypothesis was accepted.

Indicator 12: Entry points secured with guards: Secured entry points were reported by 83.3% of public institutions and 94.6% of private institutions. The chi-square test showed no statistically significant difference ($\chi^2 = 1.858$, $p = 0.173$). Therefore, the null hypothesis was accepted.

Indicator 13: Fire extinguishers and first aid kits: Fire extinguishers and first aid kits were available in 88.9% of public institutions and 91.9% of private institutions. The chi-square analysis revealed no significant difference ($\chi^2 = 0.132$, $p = 0.716$). Hence, the null hypothesis was accepted.

Indicator 14: Separate fences for transformers and pools: Separate fencing was reported by 77.8% of public institutions and 86.5% of private institutions. The chi-square test showed no statistically significant difference ($\chi^2 = 0.671$, $p = 0.413$). The null hypothesis was accepted.

Indicator 15: Rules for supervised visits to laboratories and gardens: Rules for supervised visits were reported by 83.3% of public institutions and 86.5% of private institutions. The chi-square analysis indicated no significant difference ($\chi^2 = 0.097$, $p = 0.756$). Thus, the null hypothesis was accepted.

Indicator 16: Learners oriented on safety at admission: Safety orientation at admission was reported by 94.4% of public institutions and 91.9% of private institutions. The chi-square test revealed no significant difference ($\chi^2 = 0.117$, $p = 0.732$). Accordingly, the null hypothesis was accepted.

Indicator 17: First aid room availability: First aid rooms were available in 50.0% of public institutions compared to 89.2% of private institutions. The chi-square test indicated a statistically significant difference ($\chi^2 = 10.303$, $p = 0.001$), showing a clear disparity between sectors. Therefore, the null hypothesis was rejected.

Indicator 18: Staff and learners trained in first aid: Training in first aid was reported by 55.6% of public institutions and 91.9% of private institutions. The chi-square analysis showed a statistically significant difference ($\chi^2 = 9.992$, $p = 0.002$). As a result, the null hypothesis was rejected.

Indicator 19: Well-equipped first aid kits: Well-equipped first aid kits were available in 55.6% of public institutions and 91.9% of private institutions. The chi-square test revealed a statistically significant difference ($\chi^2 = 9.992$, $p = 0.002$). Consequently, the null hypothesis was rejected.

Indicator 20: Adequate drainage functioning: Adequate drainage systems were reported by 50.0% of public institutions and 78.4% of private institutions. The chi-square analysis indicated a statistically significant difference ($\chi^2 = 4.566$, $p = 0.033$). Therefore, the null hypothesis was rejected.

Indicator 21: Garbage bins in strategic areas: Garbage bins were available in 55.6% of public institutions and 83.8% of private institutions. The chi-square test showed a statistically significant difference ($\chi^2 = 5.085$, $p = 0.024$). Hence, the null hypothesis was rejected.

Indicator 22: Drainage holes and canals covered: Covered drainage holes and canals were reported by 83.3% of public institutions and 94.6% of private institutions. The chi-square analysis showed no statistically significant difference ($\chi^2 = 1.858$, $p = 0.173$). The null hypothesis was accepted.

Indicator 23: Parking away from classrooms and playgrounds: Parking away from classrooms and playgrounds was reported by 94.4% of public institutions and 91.9% of private institutions. The chi-square test indicated no significant difference ($\chi^2 = 0.117$, $p = 0.732$). Thus, the null hypothesis was accepted.

Indicator 24: Rules on health, protection, and psychosocial support: Such rules were reported by 72.2% of public institutions and 83.8% of private institutions. The chi-square analysis

revealed no significant difference ($\chi^2 = 1.012$, $p = 0.315$). Therefore, the null hypothesis was accepted.

Indicator 25: Non-discriminatory institutional rules: Non-discriminatory rules were reported by 94.4% of public institutions and 91.9% of private institutions. The chi-square test showed no statistically significant difference ($\chi^2 = 0.117$, $p = 0.732$). The null hypothesis was accepted.

Indicator 26: Visits by professionals on bullying and health issues
Visits by professionals were reported by 77.8% of public institutions and 78.4% of private institutions. The chi-square analysis indicated no significant difference ($\chi^2 = 0.003$, $p = 0.960$). Accordingly, the null hypothesis was accepted.

Indicator 27: Disciplinary team trained on health and protection issues
Training of disciplinary teams was reported by 55.6% of public institutions and 81.1% of private institutions. The chi-square test showed a statistically significant difference ($\chi^2 = 3.978$, $p = 0.046$). Therefore, the null hypothesis was rejected.

Indicator 28: Administrative, teacher, and community support for learners
Support from administrators, teachers, and the community was reported by 55.6% of public institutions and 81.1% of private institutions. The chi-square analysis indicated a statistically significant difference ($\chi^2 = 3.978$, $p = 0.046$). As a result, the null hypothesis was rejected.

Indicator 29: Institutional contact with professionals for learner support
Institutional contact with professionals was reported by 83.3% of public institutions and 94.6% of private institutions. The chi-square test revealed no significant difference ($\chi^2 = 1.858$, $p = 0.173$). Thus, the null hypothesis was accepted.

Indicator 30: Medical teams available for emergencies: Medical teams were available in 50.0% of public institutions and 89.2% of private institutions. The chi-square analysis showed a statistically significant difference ($\chi^2 = 10.303$, $p = 0.001$). Therefore, the null hypothesis was rejected.

Findings
The findings show that both public and private inclusive institutions demonstrated strong performance in several health and safety indicators, with compliance levels of 80% and above. These areas include garbage management practices (94.4% public; 94.6% private), learners oriented on safety at admission (94.4% public; 91.9% private), non-discriminatory institutional rules (94.4% public; 91.9% private), parking away from classrooms and playgrounds (94.4% public; 91.9% private), fire extinguishers and first aid kits (88.9% public; 91.9% private), supervised visits to laboratories and gardens (83.3% public; 86.5% private), entry points secured with guards (83.3% public; 94.6% private), drainage holes and canals covered (83.3% public; 94.6% private), and institutional contact with professionals for learner support (83.3% public; 94.6% private). These findings indicate that both sectors generally meet safety and protection requirements in structurally regulated areas.
Analysing the compliance data set, a certain trend became evident with the patterns of success of private educational organizations being higher than the ones of their counterparts on several indicators. Accessibility to water that is drinkable and healthy enough to cook, prepare food were achieved by 83.8% of privately-run institutions and 72.2% of institutions in the public category; compliance with the rules and regulations of governance of health, protection and psychosocial provisions was also 83.8% compared to 72.2% respectively; proper fencing of the transformers and the swimming pools was also 86.5% among privately-run institutions compared to 77.8% among publicly-operated institutions; visit by a profession These findings consequently signify that although both industries recognize these areas, the private institutions are slightly more consistent.
In some areas private ones much higher than the public ones. That include , 89.2 % of the private schools as opposed to only 50.01 % of the public schools were found to have a dedicated first-aid room, the personnel to perform first-aid

procedures, both the staff and the students were found to have it in 91.9 percent and 55.6 percent respectively, and adequacy of first-aid kits followed suit with 91.9 percent of the private school having it as compared to 55.6 percent of the public school having it; the availability of medical teams in event of need was found at 8 This fact highlights an evident sectoral disparity in public schools, especially in the matters pertaining to emergency preparedness, emergency response capacity, and institutional support infrastructure in general.

Finally, the statistics reveal a chain of areas where both the public and the private educational institutions lack compliance. As an illustration, 11.1 per cent of public and 10.8 per cent of private schools reported nutrition programmes delivering two meals a day; trained culinary staff were available in 16.7 per cent of public schools but in 13.5 per cent of private schools, the standard kitchen facilities were reported in 27.8 per cent of the public schools and 21.6 per cent of the private schools, the availability of toilet paper in 11.1 per cent of public and 10.8 per cent of private schools, sanitary towels in These outcomes point to a similar weakness in the areas of nutrition provision and basic hygiene services in two industries.

Summary

The current study evaluated the measurement of various health and safety, sanitation, nutrition, and psychosocial assistance indicators between the two types of institutions of higher learning such as public and private inclusive schools and colleges with the objective of analysing compliance to established standards. The two industries displayed a strong activity of an over 80 percent score in some of the most crucial areas, that is, waste management procedures, fair institutional policies, safety orientation measures implemented in the moment of admission, secured ingression routes, necessitated fire and safety equipment, and active interaction with external occupation specialists. It is worth noting that, the private institutions performed better over their state counterparts in areas of first-aid preparedness, emergency medical services delivery, maintenance of infrastructures and provision of overall institutional supporting systems. On the other hand, the compliance rates both in the sectors were low regarding nutrition-related services, supply of basic hygiene needs, sufficiency of food storage and cooking facilities, and food-related garden formation. The implications of these findings highlight the glaring areas of strengths as well as the persistent areas of weaknesses evident in the health and safety environment of the assessed institutions of education.

Conclusion

Empirical evidence is that despite the simultaneous compliance of myriad health and safety levels by both governmental and privative all inclusive institutions, there are more than apparent gaps- especially in the infrastructural realms of health care and nutrition courses. High compliance with a range of WASH and structural safety indicators are consistent with the current international recommendations that highlight the urgency of health-friendly schools as sources that safeguard and boost the well-being of learners. Within the framework of the healthy learning environment conceptualized by the World Health Organization in the form of health-promoting schools, the existence of safe learning environments is theorized to have salutary impact to the physical, emotional and cognitive growth of students. A gap in the preparedness of the public institutions is demonstrated by the fact that their performance with regard to the first-aid preparedness and emergency preparedness is lower than that of the private institutions, which can be narrowed by joining forces and enhancing support and capacity building. Overall, the results highlight the fact that the implementation of inclusive and equitable education depends largely on strengthening nutrition services, a health education, and emergency health infrastructure: functions that cannot be overlooked in the process of full-scale school health programmes.

Discussion

The researchers conclude of the study offer significant empirical evidence on the health and safety conditions of the inclusive institutions that are either governmental or privately owned. In both industries, there was high levels of

compliance in a number of indicators regarding basic sanitation and structural safety including garbage management activities, safety of entrances and supply of fire safety tools. These findings are in correlation with the international frameworks that also promote comprehensive school health policies and safe water, sanitation, and hygiene, as a fundamental component of successful school health programmes (UNESCO, UNICEF, WHO, and World Bank, FRESH Framework, 2000). As it is written in the FRESH framework, WASH and health policies in schools also lead to safe learning environments, which, on the other hand, helps address the wider education objectives (UNESCO, UNICEF, WHO, and World Bank, 2000; WHO and UNESCO, 2021).

It is interesting to mention that both the public and private institutions were found to have low compliance in nutrition related indicators, including meals, trained cooks, proper food storage as well as school gardens. This tendency demonstrates a significant limitation in underlying health and nutrition services which are key toward child development and readiness to learn. School health and nutrition interventions The findings of the research support that the integrated programme based on the logic that includes the supply of nutritious foods, educational programs on nutrition, and WASH could positively influence both health-related outcomes and learning involvement of learners (Bundy et al., 2000; Sando et al., 2022). Such results indicate that nutrition services are also a point of gaps in both fields of inclusive education as part of the study setting.

The relative increase in the frequency of indicators related to emergency preparedness by the private institutions, including the first aid rooms, trained staff, and medical emergency assistance, is consistent with the data pointing to the effectiveness of structured first aid and health education in schools in increasing the level of safety, decreasing the severity of injuries and supporting the level of psychological well-being (First Aid Education Research, 2024). The observed relative shortcomings of the government institutions in these zones could either indicate variations in allocating resources, capacity development and institutional prioritisation. This trend demonstrates the significance of resource support, capacity development, and policymaking implementation, as it is suggested in the global recommendations on Health Promoting Schools (WHO, 2021; Lee, 2020).

The necessity to incorporate whole-school strategies incorporating health promotion at every level of school life, including the infrastructure, staff capacity, and community partnerships, is communicated by the number of policies and frameworks like the Health Promoting Schools movement by the World Health Organization (WHO, 2021). The health-promoting environments appear to be implemented through certain factors as indicated by the high compliance with non-discrimination rules, interactions with external professionals, and imparting learners with information about safety. These practices are aligned to the objectives of global strategies to connect health, education, and well-being to promote inclusive and secure school environments (UNESCO, 2021).

Nevertheless, the overall health and safety compliance profile demonstrated that structural safety and sanitation are fairly satisfactory, nutrition and food services, as well as integrated health support services do not perform well. This aligns with recent general studies that have indicated that school health and nutrition programmes may be challenged by the lack of resources, policy alignment, and inter-sectoral involvement (Sando et al., 2022). The findings suggest that the health, nutrition, safety, and inclusive practices must be fairly applied in both the public and private sectors, which necessitates increased policy attention, institutional capacity-building, and work with multiple sectors.

Finally, the results of the current study support the need to have complex and interdisciplinary levels of school health systems that extend beyond basic sanitation and regulatory adherence and add effective nutrition programs, first aid preparation, and sustainable health care support systems. A practical change in national education and health policy towards global models like FRESH and Health Promoting Schools can set the path to practical advances and facilitation of learner health, educational equity and inclusive settings that may lead to increased long term well being.

Recommendations

1. School authorities have it as a responsibility to hasten drafting and implementing of perfectly laid-out nutrition programmes on not only public campuses but also in the private campuses. Such programs may include, supply of timely meals, hiring of trained culinary staff, insurance of proper food storage facilities and development of the basic nutrition centres.
2. Purposeful, customized assistance to strengthen emergency preparedness to health may be given to public schools. This involves the introduction of special first aid wards, provision of multifunctional first aid kits and holding of periodic first aid training workshops among the staffs and students.
3. It may implement a comprehensive, school-wide health and safety system that may be promulgated to integrate sanitation, safety, nutrition, and psychosocial support services which may ensure that health programs are implemented in a plural and sustainable manner.
4. The educational departments maybe forced to evenly distribute resources in a strategic manner that minimizes disparity on the provision between public and private institutions, especially when it comes to improvement of infrastructure, purchase of safety gear, and even health provisions in poorly equipped schools.
5. To measure the adherence to set standards of health and safety, strong tools of frequent checking and reviewing must be put in place to ensure that any lapses are detected early enough and evidence based decisions are reached.
6. It is necessary to strengthen networks between schools, health services, local community, and bodies with the purpose of increasing professional support, developing emergency response systems, and eventually support the holistic well-being of learning communities in inclusive educational environments.

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