



Evaluating Child Protection Risks in Kismayo District Schools: Safety, Health, Environmental, and Infrastructure Challenges

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Abstract

Background: School-based safeguarding combines protection from violence with emergency preparedness, health support, hygienic facilities, and inclusive learning conditions. **Objective:** To describe teachers' and head teachers' perceptions of child protection risks in Kismayo District schools. **Methods:** The source study describes a cross-sectional questionnaire survey conducted in 2025 and reports 242 school-staff respondents (219 teachers and 23 head teachers). Five-point Likert responses were summarized descriptively and group comparisons were reported using analysis of variance (ANOVA). Frequencies were rechecked against the stated denominator of 242; no respondent-level dataset was supplied. **Results:** Most respondents considered their schools secure (205/242, 84.7%), yet fewer endorsed regular safety drills (77/242, 31.8%) or clear emergency plans (113/242, 46.7%). Fewer than half endorsed adequate health services (82/242, 33.9%) or available mental-health programmes (103/242, 42.6%). Although 208 respondents (86.0%) described school environments as clean and maintained, 39 (16.1%) disagreed that corporal punishment was absent. Reported ANOVA results indicated differences in safety ratings by age, health/hygiene ratings by experience and education, and physical-environment ratings by position. **Conclusion:** Respondents described generally positive everyday security alongside gaps in preparedness, health support, and violence prevention. Inconsistencies in source documentation limit claims about prevalence, composite scores, sampling, and causation.

Keywords: child protection; school safety; safeguarding; school health; WASH; Kismayo; Somalia; teacher perceptions

1. Introduction

Child protection is integral to educational quality because the school is simultaneously a learning environment, a setting for peer and adult interactions, and a point of contact with children who may face risks outside the classroom. Articles 19 and 28 of the Convention on the Rights of the Child recognize protection from violence and dignity in school discipline as fundamental obligations (United Nations, 1989). Globally, violence against children is widespread, although its forms and prevalence vary across populations and settings (Hillis et al., 2016). Effective safeguarding consequently requires more than gates or the absence of visible conflict: it also includes preventive procedures, reporting and referral, nonviolent discipline, hygiene, and responsive health services (World Health Organization [WHO] et al., 2019).

Water, sanitation, and hygiene (WASH) provision is part of this protective infrastructure. A review by Jasper et al. (2012) linked school water and sanitation conditions with health and educational outcomes, while McMichael (2019) documented the potential benefits and implementation barriers of WASH interventions in resource-constrained schools. The 2024 WHO–UNICEF school WASH report further shows that gaps in basic drinking water, single-sex sanitation, and hygiene services remain widespread worldwide (WHO & UNICEF, 2024). School well-being also depends on appropriately supported psychosocial services rather than a narrow focus on physical hazards (WHO & UNESCO, 2021).

In Somalia, prolonged conflict, climatic shocks, and displacement have placed pressure on education and child-protection systems. UNICEF's reporting documents the continuing need for safe and accessible learning opportunities, qualified teachers, and inclusive services in crisis-affected areas (UNICEF Somalia, 2025). Kismayo District is an important setting for school-level assessment because schools serve both established and displacement-affected communities. However, national humanitarian indicators cannot be assumed to describe individual schools, and credible local assessment requires clearly documented school samples and measures.

The original study examined perceptions of safety and security, health and hygiene, the physical environment, school infrastructure, child protection/community involvement, and perceived links to learning. Its principal research question was: **How do school staff perceive child protection conditions in Kismayo District schools, and do ratings differ by staff characteristics?** The study provides a useful empirical starting point, but source discrepancies require cautious presentation. This manuscript reports available findings as staff perceptions, not independently documented incidents, service audits, or effects on student attainment.

2. Literature Review

2.1. Theoretical perspectives

An ecological perspective treats children's safety as the outcome of interacting school, family, community, and policy environments. Bronfenbrenner (1977) emphasized reciprocal relationships between developing individuals and their social settings. Tudge et al. (2009) later stressed the importance of specifying processes, people, context, and time rather than using ecological terminology as a simple list of influences. Applied to Kismayo schools, this framework directs attention simultaneously to daily supervision, school emergency procedures, access to health providers, household vulnerability, and institutional oversight. These influences are explanatory possibilities, not causal findings of the present survey.

Social cognitive theory complements this analysis by explaining how behaviour and expectations can be influenced by social modelling and reinforcement (Bandura, 2001). Adult responses to conflict may model either nonviolent problem solving or punitive behaviour. The conceptual relevance is supported by evidence that physical punishment is associated with adverse child outcomes (Gershoff & Grogan-Kaylor, 2016), while a randomized school-based intervention in Uganda reduced violence perpetrated by school staff (Devries et al., 2015). These studies support the plausibility of positive-discipline interventions but do not establish the effectiveness of any programme in Kismayo.

2.2. Safety, emergency preparedness, and violence prevention

A school's perceived security should be distinguished from operational readiness. Clear reporting channels, rehearsed emergency procedures, and appropriately trained personnel make it possible to respond to unexpected hazards and suspected abuse. Guidance produced by WHO, UNESCO, and UNICEF (2019) places prevention, school-level procedures, and intersectoral coordination within routine educational management. For protection against violence, the Good School Toolkit trial by Devries et al. (2015) provides evidence that school culture and staff practice can be changed through structured interventions. Such evidence supports an emphasis on prevention rather than relying solely on generalized staff confidence that a school feels safe.

2.3. Health, psychosocial support, and hygiene

School health services contribute to protection when children can obtain first aid, appropriate referral, health information, and support for emotional distress. WHO and UNESCO (2021) identify school policies, social environments, services, and school-community partnerships as interconnected components of health-promoting schools. Displaced and conflict-affected children may have additional psychosocial needs, although studies of refugee mental-health interventions underscore that effectiveness varies and context-sensitive evaluation is necessary (Lawton & Spencer, 2021). These findings argue for accessible referral systems and staff training without assuming that every school requires the same clinical model.

Reliable drinking water, hygienic toilets, accessible facilities, and waste-management systems can help reduce avoidable health and dignity risks (Jasper et al., 2012; McMichael, 2019). WHO and UNICEF (2024) also highlight the specific importance of usable, sex-separated sanitation for schoolgirls. Nevertheless, the existence of a waste bin or perceived cleanliness does not directly establish sufficient water supply, disability access, menstrual-health provision, or disease prevention: those outcomes require targeted measures or observation.

2.4. Physical environment, inclusion, and learning

A protective physical environment encompasses safe buildings, maintenance, accessible circulation, protection from harmful discipline, and arrangements that support children with varied needs. The UN Convention links discipline explicitly to human dignity (United Nations, 1989). Positive school climate and psychosocial skills can also relate to educational engagement; a meta-analysis of school-based social and emotional learning interventions reported improvements in several student outcomes, including academic performance (Durlak et al., 2011). These associations from external literature should not be mistaken for directly measured learning gains in Kismayo.

2.5. Research gap and analytical focus

The accessible research and institutional evidence identifies multidimensional protection challenges, yet it does not substitute for local school-level information. The study contributes descriptive perspectives from education personnel in Kismayo, focusing on routine security, preparedness, health and hygiene, and environmental conditions. Its analytic value depends on maintaining a separation between reported perceptions, verified response frequencies, composite statistics that cannot be recalculated, and proposed interventions requiring future evaluation.

3. Methodology

3.1. Design, setting, and participants

The source describes a quantitative, cross-sectional school-staff questionnaire survey in Kismayo District, Jubaland State, Somalia, in 2025. The methods section specifies data collection during July–August 2025, while one scope passage specifies June–July 2025; the exact fieldwork dates should be checked against records. Reported participants numbered 242: 219 teachers and 23 head teachers. The source alternately identifies 22 and 23 schools, and refers both to primary-only and to primary-and-secondary settings. Because no school register or sampling log was provided, the definitive number and types of participating schools are unresolved.

The manuscript says random sampling was used, but its descriptions of the population frame conflict (figures of 523, 528, and 650 are given) and do not identify a reproducible selection procedure. The stated Slovin calculation, $n = N/[1 + N(e^2)]$, using $N = 650$ and $e = .05$, yields approximately 248 rather than 242. Consequently, the present article treats 242 as the reported achieved respondent count, not as a statistically verified probability-sample target or evidence of district-wide representativeness.

3.2. Instrument and statistical analysis

The study used a structured five-point agreement scale (1 = strongly disagree to 5 = strongly agree) covering safety, health and hygiene, and environmental/protection conditions. SPSS version 25 was reportedly used for frequency distributions, percentages, means, standard deviations, and one-way ANOVA comparisons across sex, age, experience, education, and position. This revision independently recomputed descriptive percentages from the displayed frequencies using the declared total of 242. Response counts were not imputed when reported categories did not total 242. All ANOVA results and composite scores are transcribed as reported because respondent-level records, scale keys, and analysis syntax were unavailable.

The original text describes expert face review and Cronbach’s alpha at or above .70, but does not supply item-specific reliability estimates, an instrument appendix, pilot-test size, or supporting output. A reported “validity” coefficient of .83 appears to have been obtained by taking the square root of a reliability coefficient; this is not, by itself, evidence of content or construct validity. Internal consistency and validity are different measurement properties (Tavakol & Dennick, 2011). The instrument therefore requires further psychometric documentation.

3.3. Ethics and limitations of the reporting record

The source affirms that ethical principles were respected, but provides no verifiable ethics committee identifier, participant consent wording, or data-protection protocol. The study involved adult school personnel; no child interviews or child-level records were documented. Missing procedural details should be supplied by the original investigators rather than reconstructed retrospectively. Because teachers and head teachers reported perceptions at one time point, the design does not establish causal effects on child protection or actual student learning outcomes.

4. Results

4.1. Respondent characteristics

All five demographic tables state a total of 242 respondents. Men represented 90.9% and women 9.1%, indicating substantial gender imbalance in the accounts available. The largest age group was 41 years and older (45.0%), and 67.4% were categorized as underqualified in the source; however, the operational criterion for “underqualified” was not specified. Teachers comprised 90.5% of respondents based on the frequencies, correcting an erroneous percentage in the original position table.

Table 1. Profile of survey respondents (N = 242)

Characteristic	Category	n	%
Sex	Male	220	90.9
	Female	22	9.1
Age	20–30 years	51	21.1
	31–40 years	82	33.9
	41 years and above	109	45.0
Position	Teacher	219	90.5
	Head teacher	23	9.5
Qualification status	Qualified	79	32.6
	Underqualified	163	67.4
Education	Diploma	143	59.1
	Bachelor's degree	92	38.0
	Master's degree	7	2.9

4.2. Safety and emergency preparedness

Agreement that the school felt secure was high (84.7%), and 75.2% endorsed the availability of sufficient trained staff. Yet only 31.8% agreed that drills were conducted regularly; 49.2% disagreed. Fewer than half (46.7%) endorsed a clear emergency response plan, and 35.5% disagreed. These contrasts identify an important gap between perceptions of everyday security and reported preparedness. The trained-staff item recorded 237 rather than 242 categorized responses, so its neutral and disagreement proportions are reported against 242 without allocating the remaining five records.

4.3. Health and hygiene

Adequate health services received positive ratings from 33.9% and negative ratings from 49.2% of respondents. Mental-health programmes were endorsed by 42.6%; 36.4% disagreed. Health-and-nutrition information was endorsed by 45.9%, while 47.9% agreed that disease-prevention measures existed. Staff reported relatively higher student awareness of safety protocols (70.2%), though this particular item also accounted for only 237 responses in the source frequency categories. These answers indicate unevenly perceived provision, not independent verification of the existence, quality, or utilization of any service.

4.4. Physical environment and discipline

Most staff endorsed the description of a clean, well-maintained environment (86.0%), adequate waste-disposal facilities (65.3%), and environmentally friendly practices (82.6%). A majority (69.0%) agreed with the positively phrased statement that corporal punishment was not practiced. Importantly, 16.1% disagreed with that statement and 14.9% were neutral. This supports concern about possible continued use or uncertainty surrounding violent discipline, but does not establish a verified prevalence of corporal-punishment incidents.

Table 2. Recalculated agreement patterns for reported survey items

Domain	Survey statement	Agree ¹	Neutral	Disagree ²
Safety	Sufficient trained staff	182 (75.2%)	23 (9.5%)	32 (13.2%)
Safety	School feels secure	205 (84.7%)	21 (8.7%)	16 (6.6%)
Safety	Regular safety drills	77 (31.8%)	46 (19.0%)	119 (49.2%)
Safety	Clear emergency response plan	113 (46.7%)	41 (16.9%)	86 (35.5%)
Health	Students aware of safety protocols	170 (70.2%)	37 (15.3%)	30 (12.4%)
Health	Adequate health services	82 (33.9%)	41 (16.9%)	119 (49.2%)
Health	Mental-health programmes	103 (42.6%)	51 (21.1%)	88 (36.4%)
Health	Healthy lifestyle/nutrition information	111 (45.9%)	57 (23.6%)	74 (30.6%)
Health	Disease-prevention measures	116 (47.9%)	44 (18.2%)	82 (33.9%)
Environment	Corporal punishment not practiced	167 (69.0%)	36 (14.9%)	39 (16.1%)
Environment	Clean/maintained environment	208 (86.0%)	24 (9.9%)	10 (4.1%)
Environment	Adequate waste-disposal facilities	158 (65.3%)	53 (21.9%)	31 (12.8%)
Environment	Environmentally friendly practices	200 (82.6%)	31 (12.8%)	11 (4.5%)

4.5. Reported composite scores

The source additionally presents five domain-level means and standard deviations (Table 3). Health and hygiene was the lowest-rated domain ($M = 3.13$), whereas perceived impact on learning outcomes was highest ($M = 3.89$). However, item-level frequencies were provided only for parts of three domains, and the scoring/reverse-scoring procedures and domain composition were not documented. The aggregate scores therefore cannot be independently reconciled with the available item counts and are retained as **reported, unverified** summary statistics. In particular, the label “Perceived Impact on Learning Outcomes” measures staff beliefs in the available text, not observed achievement, attendance, or retention.

Table 3. Domain statistics as reported in the source (not independently reproducible)

Domain	M	SD	Verification status
Safety and security	3.26	1.11	Composite scoring unavailable
Health and hygiene services	3.13	1.16	Composite scoring unavailable
Physical environment and infrastructure	3.57	1.10	Composite scoring unavailable
Child protection and community involvement	3.67	1.06	Supporting item tables unavailable
Perceived impact on learning outcomes	3.89	0.98	Supporting item tables unavailable

Note. M = reported grand mean on the five-point scale; SD = reported standard deviation. Domain construction and respondent-level data were not supplied.

4.6. Group comparisons by respondent characteristics

Source ANOVA summaries indicated statistically significant differences in safety/security ratings across age groups, $F(2, 239) = 4.78, p = .009$; in health/hygiene ratings by experience, $F(1, 240) = 15.43, p < .001$, and education, $F(2, 239) = 3.88, p = .022$; and in physical-environment ratings by position, $F(1, 240) = 4.12, p = .044$. The remaining comparisons were reported as not statistically significant at the nominal .05 threshold (Table 4). Because group means, post hoc tests, model assumptions, and multiple-comparison adjustments are absent, the direction, practical magnitude, and robustness of these differences cannot be established.

Table 4. ANOVA results transcribed from the source

Rated domain	Grouping variable	F	df (between, within)	p
Safety/security	Age	4.78	2, 239	.009
	Experience	1.23	1, 240	.268
	Education	2.15	2, 239	.119
	Position	0.87	1, 240	.352
	Sex	0.45	1, 240	.503
Health/hygiene	Age	2.89	2, 239	.058
	Experience	15.43	1, 240	< .001
	Education	3.88	2, 239	.022
	Position	2.34	1, 240	.127
	Sex	0.92	1, 240	.339
Physical environment	Age	1.05	2, 239	.351
	Experience	0.78	1, 240	.378
	Education	1.45	2, 239	.237
	Position	4.12	1, 240	.044
	Sex	0.21	1, 240	.647

5. Discussion

5.1. Security confidence is not equivalent to readiness

The most salient contrast is between high staff-perceived security (84.7%) and low support for routine drills (31.8%). A school may appear calm under everyday conditions yet be poorly prepared for fire, flooding, intrusion, or medical emergencies. This interpretation aligns with school-based prevention guidance that emphasizes planned responses and trained adults (WHO et al., 2019). The survey cannot show that unpracticed emergencies produced injuries, but the gap provides a credible rationale for systematic preparedness reviews. Similarly, perceived sufficiency of trained staff should be corroborated by training records and demonstrated competencies, not agreement responses alone.

5.2. Health-support gaps and integration with external services

The clearest negative item-level pattern concerned the perceived adequacy of health services: 49.2% disagreed that provision was adequate. Mental-health support was reported less negatively but remained uncertain or contested for many respondents. WHO and UNESCO (2021) recommend a whole-school approach linking facilities, policies, services, and community relationships, which is relevant where school resources are constrained. It would, however, be unjustified to describe the survey as demonstrating the near-total absence of healthcare or mental-health support: sizeable minorities endorsed both services. A practical next step is to verify first-aid availability, trained focal points, service utilization, and established pathways to qualified providers.

5.3. Environmental cleanliness does not rule out interpersonal risk

Positive ratings of cleanliness (86.0%) and environmental practices (82.6%) represent perceived school strengths worth sustaining. Nevertheless, 39 respondents disagreed with the assertion that corporal punishment was absent. Research has linked physical punishment to adverse child outcomes (Gershoff & Grogan-Kaylor, 2016), and the Ugandan Good School Toolkit trial demonstrates that school-level violence prevention is amenable to intervention (Devries et al., 2015). Kismayo schools should therefore distinguish visible environmental management from child-centred protections against violent discipline, bullying, and unsafe reporting. Direct student testimony obtained safely, confidential reporting analysis, and independent observation would be needed to assess incidence rather than adult perceptions.

5.4. Inclusion, infrastructure, and perceived learning

The source associates infrastructure with disability access and girls' sanitation needs, but its displayed item frequencies do not directly measure ramps, toilets, classroom accessibility, menstrual hygiene, boundary walls, or structural integrity. These are important priorities in light of WASH evidence (Jasper et al., 2012; WHO & UNICEF, 2024), but they remain recommendations for assessment rather than findings verified by this dataset. The reported high mean for "impact on learning outcomes" should also be interpreted carefully: teachers may understand safe, healthy schools as conducive to learning, but the study provides no test scores, dropout measures, absenteeism records, or longitudinal outcomes. External evidence on social-emotional learning (Durlak et al., 2011) cannot convert the present cross-sectional opinions into causal educational impacts.

5.5. Variation in staff ratings and methodological constraints

Reported age, experience, education, and position differences indicate that staff members did not answer identically across all groups. Yet the document lacks directions of differences, confidence intervals, effect sizes, post hoc comparisons, and correction for multiple tests. The strongly male sample and undefined "underqualified" classification also limit interpretation, particularly for gender-sensitive safeguarding. Moreover, school counts, population frames, timing, and two item-frequency totals conflict internally. These problems do not erase the descriptive concerns, but they preclude strong assertions about representative district prevalence and reduce confidence in the summary indices. A future evaluation should prioritize a verified school roster, transparent probability procedures where feasible, respondent-level anonymized data, item-key documentation, and direct child-sensitive measures.

6. Conclusion

This study's reported staff responses suggest a multidimensional and uneven protective environment in Kismayo District schools. Schools were generally perceived as secure, clean, and environmentally well managed, while emergency drills, adequate health services, and consistent psychosocial provision received notably weaker ratings. A minority also questioned whether corporal punishment had been eliminated. These patterns are relevant to school improvement, but they describe perceptions from an incompletely documented sample and should not be treated as verified district-wide prevalence, established policy violations in named institutions, or measured effects on student outcomes. An integrated safeguarding response should combine emergency readiness, health referral, positive discipline, inclusion audits, and credible monitoring.

7. Recommendations

1. Institutionalize emergency preparedness. District education authorities and school leaders should require written, child-accessible emergency plans, assigned focal points, routine scenario-based drills, and documented after-action reviews. A baseline audit should verify whether staff and students can explain evacuation and referral procedures.

2. Establish minimum school-health safeguards. Each school should assess first-aid supplies, appropriately trained staff, infection prevention, safe water, and referral links with local health facilities. Mental-health and psychosocial

support should begin with safe identification, basic staff orientation, and referral rather than assuming that every school can immediately provide specialist clinical services (WHO & UNESCO, 2021).

3. Prevent corporal punishment and strengthen reporting. Adopt explicit nonviolent-discipline codes, provide practical positive-discipline training, offer confidential child-appropriate reporting options, and define procedures for recording, investigating, and referring suspected abuse. Implementation should be monitored rather than inferred from policy existence (Devries et al., 2015).

4. Audit inclusion and WASH facilities. Conduct school-by-school observational assessments of usable sex-separated toilets, handwashing with soap, drinking water, accessibility for children with disabilities, lighting, safe buildings, and waste management. Prioritize remedial work using transparent risk and equity criteria (WHO & UNICEF, 2024).

5. Strengthen workforce capability and representation. Verify teacher qualifications against transparent criteria, establish recurrent safeguarding and first-aid training, and improve opportunities for qualified women to enter teaching and school leadership. Male- and female-staff representation should be considered alongside safe reporting mechanisms rather than assuming that staff sex alone ensures protection.

6. Strengthen measurement and follow-up research. Reconcile the school roster, study dates, sampling population and formula, and two incomplete item tables; archive the questionnaire and scoring key; report alpha coefficients per scale and appropriate validity evidence; and make anonymized data and statistical syntax available where ethics and data protection permit. Follow-up studies should include ethically safeguarded child perspectives, verified facilities, and prospective measures of attendance and well-being to test programme effects.

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