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Trauma-Informed Care in Early Childhood Development: Assessing the Preparedness of Bulawayo ECD Centres to Address the Psychosocial Needs of Children Displaced by Xenophobic Violence in South Africa

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Abstract: *The mid-2026 xenophobic uprisings in South Africa precipitated the forced return of thousands of Zimbabwean children, with Bulawayo's Early Childhood Development (ECD) centres absorbing a primary share of displaced learners. Although presidential policy directives mandated school enrolment access, institutional preparedness to address underlying psychosocial trauma remained unassessed. This study evaluated the preparedness of Bulawayo ECD centres to deliver trauma-informed care (TIC) to xenophobia-displaced children across government, council and private settings. Employing a convergent parallel mixed-methods design grounded in SAMHSA's four Rs framework and Bronfenbrenner's ecological systems theory, data were gathered from 80 educators (via an adapted ARTIC scale), 10 school administrators and 15 parents. Quantitative results revealed moderate general trauma awareness among educators (M = 3.34) but critically low symptom recognition capacity (M = 2.18) and practice self-efficacy. Qualitative findings underscored a complete absence of dedicated school counsellors, persisting corporal punishment of trauma-driven behaviours in 34.6% of settings and heavy parental reliance on informal support. Private centres outperformed public settings primarily due to non-governmental training access rather than systemic capability. The study concludes that Bulawayo's ECD infrastructure is structurally unprepared for TIC delivery. To prevent secondary harm and support early development, urgent contextual adaptations are required, including specialized educator training, institutional referral protocols and inter-ministerial policy coordination.*

Keywords: *Trauma-informed care; Early childhood development; Xenophobic displacement; Bulawayo; Psychosocial support; Educator preparedness*

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1. Introduction

Childhood exposure to violence, forced displacement and community upheaval constitutes one of the most severe threats to healthy early development. Neuroscientific evidence has established that toxic stress during the critical window of ages zero to eight can permanently alter brain architecture and compromise socio-emotional regulatory capacities in ways that persist into adulthood (Shonkoff & Garner, 2012; Perry, 2009; van der Kolk, 2014). These consequences are not abstract. They show up in the child who cannot sit still, who lashes out at peers, who stares blankly at instructions, or who, in the most heartbreaking cases, expresses a wish not to be alive. For children in early childhood development (ECD) settings, where foundational cognitive, linguistic and socio-emotional capacities are being formed, unaddressed

trauma can derail developmental trajectories that are extraordinarily difficult to correct later (National Scientific Council on the Developing Child, 2020). Globally, an estimated 43 million children under twelve currently live in displacement contexts, many without any structured psychosocial support within their educational environments (UNHCR, 2023). The systems that receive them are, more often than not, unprepared.

The Southern African region has not been exempted from this crisis. Xenophobia (the fear, hostility and organised violence directed at foreign nationals) has been a recurring feature of South Africa's post-apartheid landscape, with documented episodes of mass violence in 2008, 2015 and 2019 (Crush & Ramachandran, 2020; Misago, 2019). Each wave has displaced thousands of migrant families, many of Zimbabwean origin, from communities they had inhabited for years. Zimbabwean nationals constitute one of the largest migrant populations in South Africa, driven there by economic collapse and political instability at home (Chikanda & Crush, 2023). Their children, born or raised partly in South Africa, have in many cases been educated entirely within the South African schooling system. When xenophobic violence erupts, these children lose not only their homes but their schools, their friends, their language environments and the fragile stability that education provides.

What unfolded in mid-2026 was, by all available accounts, qualitatively different in scale from previous episodes. The uprisings that swept across several South African provinces in June and July resulted in the forced expulsion of tens of thousands of Zimbabwean nationals, with children abruptly removed from schools and transported or fled across the Beitbridge border post (NewsDay Zimbabwe, 2026; The Herald, 2026). Bulawayo, Zimbabwe's second-largest city, received a significant proportion of these returning families. The Zimbabwean president Mnangagwa issued a directive that no returning child should be denied enrolment, a political commitment that was necessary but, as events have shown, far from sufficient (The Herald, 2026). Schools opened their doors. The children came. What awaited them inside those classrooms was, in many cases, woefully inadequate for what they were carrying.

The psychosocial crisis facing ECD-age returnee children in Bulawayo is not a peripheral concern. It sits at the centre of what these children need in order to learn, develop and recover. Reports from social welfare organisations and community health workers in Bulawayo describe children presenting with nightmares, regressive behaviour, selective mutism, extreme separation anxiety and, in a number of cases, suicidal ideation upon being told they were leaving South Africa (Pongweni & Metelerkamp, 2026). These are children in psychological crisis, many at the ECD level, where the capacity for emotional self-regulation is still being neurologically wired. Trauma-informed care (TIC), a practice framework that reorganises educational environments around an understanding of trauma's pervasive impact on learning, has been implemented with measurable success in various global educational contexts (SAMHSA, 2014; Cole et al., 2005; Dorado et al., 2016).

The question that remains unanswered and that this study addresses, is whether Bulawayo's ECD centres possess the knowledge, structures, resources and trained personnel to actually deliver it.

This is a significant gap; empirically, practically and morally. The literature on TIC in educational settings is dominated almost entirely by research from North America, the United Kingdom and Australia (Maynard et al., 2019; Thomas et al., 2019). African ECD contexts, with their distinct resource constraints and cultural frameworks of childhood and healing, have received almost no attention in TIC scholarship. Within Zimbabwe specifically, no published empirical study, to this researcher's knowledge, has examined TIC readiness in ECD settings, let alone in the context of mass xenophobic displacement. Importing a framework designed for well-resourced Western environments into a Zimbabwean ECD centre, without understanding what capacity actually exists, risks producing not a trauma-informed environment but a performative one, where the language of TIC is adopted without the substance. Children deserve more than that.

1.1 Statement of the Problem

The sudden re-absorption of thousands of Zimbabwean children displaced by the 2026 xenophobic uprisings in South Africa presented an acute operational and pedagogical crisis for Early Childhood Development (ECD) centres in Bulawayo. While executive directives successfully removed administrative barriers to physical school enrolment, they created a profound structural mismatch between the complex psychosocial needs of traumatized returnee children and the institutional capacity of receiving schools. Children in the critical developmental window of ages zero to eight are presenting with acute stress reactions, emotional dysregulation, selective mutism and severe separation anxiety. However, Zimbabwean ECD policy and educator training remain almost exclusively oriented toward cognitive and academic benchmarks, lacking formal mandates or frameworks for trauma-informed care (TIC). Consequently, educators are forced to manage complex trauma responses without diagnostic tools, institutional referral pathways, or specialized psychological support personnel. This systemic unpreparedness risks misinterpreting trauma responses as disciplinary infractions—potentially re-traumatizing vulnerable children through punitive measures—while leaving educators overwhelmed and parents isolated in managing developmental recovery. Without an empirical evaluation of existing TIC readiness and structural bottlenecks in receiving centres, educational interventions remain purely administrative, leaving displaced learners without the safe, trauma-responsive environments required for healthy neurodevelopment and learning.

1.2 Research aim and questions

This study, therefore, aims to assess the preparedness of Bulawayo's ECD centres to provide trauma-informed care to children displaced by the 2026 xenophobic violence in South Africa, drawing on the perspectives of

ECD educators, school administrators and parents or guardians of affected children. The following research questions guide the inquiry:

RQ1: What is the current level of trauma-informed care knowledge and preparedness among ECD educators in Bulawayo's ECD centres?
RQ2: What institutional structures, resources and referral pathways exist in Bulawayo's ECD centres to support the psychosocial needs of xenophobia-displaced children?
RQ3: How do parents and guardians of displaced children perceive and experience the psychosocial support available through ECD centres in Bulawayo?
RQ4: What barriers constrain the implementation of trauma-informed care in Bulawayo's ECD centres?

1.3 Significance of the study

The study carries significance on several levels. For ECD practitioners, it surfaces the lived realities of classroom-level psychosocial challenge in a context that has been rendered invisible in both academic and policy discourse. For policymakers, it provides evidence (drawn from Bulawayo's own educational landscape) to inform the translation of the presidential enrolment directive into a genuinely supportive educational experience for displaced children. For scholars, it opens a conversation about TIC in African ECD contexts that is long overdue. The child who sat in a South African classroom in May 2026 and was in a Bulawayo ECD centre by July of the same year did not only cross a border. That child crossed worlds. Whether the educational system that received them was ready to hold that crossing with care is what this study seeks to find out.

1.4 Organisation of the study

The remainder of this paper is organised as follows. Section 2 reviews the relevant literature across four thematic areas; childhood trauma and its developmental consequences; TIC frameworks and their application in educational settings; xenophobia, displacement and psychosocial well-being in African contexts; and ECD policy and practice in Zimbabwe. Section 3 presents the theoretical framework guiding the study. Section 4 describes the research methodology, including design, sampling, data collection and analysis procedures. Section 5 presents the findings. Section 6 offers a discussion of findings in relation to the literature and theoretical framework. Section 7 addresses implications for practice, policy and future research. Section 8 acknowledges the limitations of the study and Section 9 draws the paper to a close.

2. Literature Review

2.1 Childhood Trauma, Early Development and Educational Outcomes

The relationship between early childhood trauma and disrupted development is one of the most consistently documented findings across neuroscience, developmental psychology and education research. What is less consistently appreciated, particularly in African educational discourse, is just how specific and lasting those disruptions are. Perry's (2009) neurosequential model of therapeutics offers a useful starting point here. The model proposes that the brain develops in a sequential, hierarchical manner, with lower-order regulatory structures (governing stress responses, arousal and impulse control) forming before higher-order cortical functions that support learning, language and reasoning. When a child experiences chronic fear or threat during these early formative years, the brain's stress-response architecture becomes dysregulated in ways that actively compete with the neural pathways needed for academic engagement. It is not that traumatised children cannot learn. It is that their brains are, quite literally, organised around survival rather than curiosity.

Van der Kolk (2014) adds an important dimension to this picture by demonstrating that trauma is not simply a psychological experience; it is a somatic one. The body stores the physiological residue of threatening events and children who have experienced repeated exposure to violence, displacement, or community breakdown carry that residue into classrooms in the form of hypervigilance, dissociation and a nervous system that interprets ordinary social interactions as potential threats. Shonkoff and Garner (2012) describe this as toxic stress, distinguishing it from tolerable or positive stress by its chronicity, its lack of buffering adult support and its capacity to produce lasting changes in brain structure and function. Critically, the ages zero to eight represent the period of greatest neurological vulnerability and, simultaneously, the greatest potential for intervention (National Scientific Council on the Developing Child, 2020). The educational consequences of unaddressed trauma during this window are well documented; impaired working memory, reduced executive function, language delays, difficulty forming peer relationships and a general erosion of the capacity to engage with structured learning environments (Shonkoff & Garner, 2012; Thomas et al., 2019).

What the earlier literature does not always make sufficiently clear is the distinction between single-incident trauma and what Herman (1992) first termed complex trauma. Cook et al. (2005) elaborated this concept to describe the cumulative impact of multiple, prolonged and interpersonal traumatic experiences, particularly those occurring within systems that were supposed to provide safety. Xenophobic displacement fits this description almost precisely. The children expelled from South African schools in 2026 did not experience a single frightening event from which they could recover with time. They experienced the destruction of their homes, the violent removal from their communities, separation from friends and familiar environments, a terrifying border crossing and then immediate enrolment into an unfamiliar school system in a country many of them had never fully lived in. Each of these transitions constitutes a traumatic layer. Together, they constitute a complex traumatic experience that the existing ECD

literature, focused as it largely is on domestic abuse and single-community disasters, has not adequately theorised for children in xenophobic displacement contexts.

2.2 Trauma-Informed Care in Educational Settings: Conceptual Foundations and Evidence

Trauma-informed care, as a school-based framework, is perhaps most clearly articulated in SAMHSA's (2014) conceptual guidance, which positions TIC not as a clinical treatment but as an organisational philosophy. The distinction matters enormously, because it shifts responsibility for trauma response from individual counsellors or therapists (who are rarely available in under-resourced schools) to the institution as a whole. SAMHSA's four Rs framework (Realise, Recognise, Respond and Resist Re-traumatisation) provides an operationalisable structure; all staff come to understand the widespread impact of trauma on development and behaviour (Realise); they develop the skill to identify signs of trauma in learners (Recognise); the school's practices, policies and procedures are organised to respond to trauma-affected learners with sensitivity (Respond); and the institution actively works to avoid practices that might re-traumatise children, such as punitive discipline for trauma-driven behaviour (Resist Re-traumatisation). This framework is appealing precisely because it does not require specialist clinical staff in every classroom. It requires institutional will, trained educators and a culture of safety.

The empirical evidence for TIC in school settings is growing, though it is not without its complications. Studies conducted in American and Australian primary schools have reported measurable improvements in school attendance, reductions in disciplinary exclusions and stronger teacher-learner relational quality following TIC implementation (Cole et al., 2005; Dorado et al., 2016; Craig, 2016). Thomas et al. (2019), in their interdisciplinary review spanning two decades of research, concluded that trauma-informed school practices show consistent associations with improved student behaviour and reduced staff burnout when implemented as a whole-school approach rather than a piecemeal add-on. Greenberg et al. (2017) similarly argue that TIC achieves its most durable effects when embedded within broader frameworks of school mental health that include social-emotional learning, staff wellness programmes and community partnerships.

Taken together, this evidence is encouraging. It is also, however, almost entirely generated in North American, European and Australian contexts. Maynard et al. (2019), in their systematic review of TIC programmes across schools, noted that the evidence base is heavily skewed toward high-income, English-speaking countries with relatively well-resourced mental health infrastructures. They raise a question that has not yet been adequately answered; to what extent are TIC outcomes generalisable to contexts where schools lack counsellors, class sizes far exceed recommended ratios, educator salaries are insufficient to sustain professional motivation and community mental health services are either absent or deeply stigmatised? This is not a peripheral concern for a study situated in Bulawayo. It is the central concern. The TIC literature, for all its growth, has produced virtually no evidence from sub-Saharan African ECD settings. There are passing references in some African education and mental health journals to trauma-sensitive teaching practices, but nothing that constitutes a systematic examination of TIC as a framework in an African ECD context (Nkwanyana & Murris, 2020). The risk, therefore, is that TIC remains a borrowed concept applied uncritically to settings whose structural and cultural realities it was never designed to accommodate.

There is also a tension within the TIC literature itself that deserves acknowledgement. Some scholars, including Venet (2021), have begun to argue that TIC as currently conceptualised can inadvertently individualise structural problems, focusing on building children's resilience without sufficiently interrogating the social and political conditions that produce trauma in the first place. This is a legitimate critique, and it is particularly relevant in the context of xenophobic displacement, where trauma is not the result of individual pathology or family dysfunction but of organised communal violence enabled by state inaction. A trauma-informed ECD centre that helps a child regulate their emotions without ever addressing why that child had to flee their community in terror is, at best, a partial response. This study takes seriously both the value of TIC as a practice framework and the limitations of its current conceptualisation when applied to politically produced trauma.

2.3 Xenophobia, Forced Displacement and Psychosocial Well-being in African Contexts

Xenophobic violence in South Africa is not a new phenomenon and the academic literature on its causes, dynamics and consequences has grown considerably over the past fifteen years. Landau (2011), writing in the aftermath of the devastating 2008 attacks, described xenophobia in South Africa as a structurally embedded feature of a society navigating deep inequalities of class, race and citizenship, rather than simply an expression of popular frustration. Misago (2019) similarly argued that xenophobic violence operates through organised networks of community actors, making it qualitatively different from spontaneous crowd violence and significantly more traumatising for victims who often receive no protection from the very state institutions (police, local government) that are supposed to keep them safe. The psychological sequelae for adult survivors are well documented; clinical presentations of post-traumatic stress disorder (PTSD), depression, grief reactions, severe disruption to identity and a pervasive loss of trust in social and institutional structures (Mthembu & Khoza-Shangase, 2018). What is far less documented is the impact on children and particularly on children at the ECD level.

Research specific to Zimbabwean migrants and returnees adds an important layer of contextualisation. Tawodzera

(2014) documented the precarious health and social welfare conditions of Zimbabwean migrants in South African urban spaces, noting that their exclusion from formal safety nets meant that experiences of violence were rarely followed by any structured psychosocial support. Chikanda and Crush (2023) traced the cyclical nature of Zimbabwean migration to and from South Africa, noting that many families experience multiple episodes of forced return, which has cumulative effects on children's sense of stability and belonging. The concept of "return migration" in this literature is treated primarily through an economic lens, examining livelihood strategies and labour market reintegration. The psychosocial dimensions of return and particularly the educational and developmental needs of returning children, remain peripheral.

The broader literature on education in emergencies provides some useful framing. Dryden-Peterson (2016) argued that educational continuity is not merely a practical necessity for displaced children but a psychosocial protective factor, providing structure, routine and a sense of normality that buffers against the worst psychological effects of displacement. Mendenhall (2014) similarly documented how schools serving displaced populations can function as psychosocial anchors when they are equipped to do so and as additional sites of harm when they are not. The Inter-Agency Network for Education in Emergencies (INEE, 2010) has produced minimum standards for education in emergency contexts, including provisions for psychosocial support, but these standards have been developed primarily for conflict and natural disaster contexts and have been applied inconsistently in situations of xenophobic displacement, which do not always meet formal definitions of "emergency" even when their human consequences are equally severe.

Here lies a gap that this study takes seriously. The existing scholarship treats xenophobic displacement primarily as a political and economic phenomenon. It treats forced migration and education mostly in the context of war, refugee camps and cross-border flight. The specific situation of children displaced by xenophobic (rather than conflict-driven) violence, returning to a country they may barely know, being enrolled in ECD centres that were not designed to receive them, in a city (Bulawayo) whose institutional capacity for psychosocial support is already stretched, has not been examined in its own right. This is not merely a gap in the academic record. It represents a silence about children whose suffering is real and whose needs cannot wait for scholarship to catch up.

2.4 ECD Policy and Practice in Zimbabwe: An Overview

Zimbabwe's formal ECD policy landscape has evolved considerably over the past decade, reflecting a growing political acknowledgement that early childhood education is not a luxury but a developmental necessity. The Constitution of Zimbabwe (2013), under Section 75, establishes education as a fundamental right for every citizen, with the state obligated to take reasonable measures to achieve progressive realisation of this right. The Education Amendment Act (No. 2 of 2020) took a significant step by formally integrating ECD (covering children aged three to five) into the structure of formal schooling, making ECD the first two years of primary education rather than a separate and often informal sector. The National ECD Policy (Ministry of Primary and Secondary Education, 2016) further set out standards for ECD provision, including provisions for child safety, holistic development and community involvement.

These policy commitments are meaningful on paper. The resource environment within which they must be implemented is, however, a different story. Mugweni and Dakwa (2013), in one of the few studies focusing specifically on ECD implementation challenges in Zimbabwe, documented severe constraints in physical infrastructure, educator-to-learner ratios and the quality of pre-service training that ECD practitioners receive. Chikwiri and Musiyiwa (2017) found that ECD educators in Zimbabwe frequently reported feeling professionally isolated, under-equipped and without access to supervision or continuing professional development. Psychosocial support infrastructure is almost entirely absent in most government and council ECD centres; school counsellors are a rarity in primary schools generally and their presence in ECD settings specifically is essentially non-existent. What is particularly striking, given the current study's focus, is that neither the Education Amendment Act (2020) nor the National ECD Policy (Ministry of Primary and Secondary Education, 2016) contains any explicit provision for trauma-informed practice, psychosocial first response, or mental health referral pathways within ECD settings. The word "trauma" does not appear in either document. This is not simply an oversight. It reflects a broader conceptualisation of ECD in Zimbabwe that is oriented primarily toward cognitive and academic readiness rather than holistic psychosocial wellbeing, a conceptualisation that was already inadequate before the events of 2026 and is now dangerously misaligned with the needs of the children arriving in Bulawayo's ECD centres.

Transitional Synthesis

Taken together, the literature reviewed in this section reveals a pattern of convergent inadequacy. The neuroscientific and developmental literature makes an overwhelming case for the urgency of early intervention for trauma-affected children. The TIC literature offers a promising institutional framework but has generated almost no evidence from African ECD contexts, leaving unresolved questions about cultural fit, resource feasibility and structural adaptability. The literature on xenophobia and displacement in southern Africa documents the psychological harm suffered by adult victims in considerable detail but largely overlooks children's specific experiences and needs. Zimbabwe's ECD policy framework represents genuine political commitment to early childhood education, but that framework carries no provisions for psychosocial support or trauma-responsive practice. What emerges from placing these literatures in conversation with one another is a specific and urgent knowledge gap; there is, to this researcher's knowledge, no published empirical study that

has examined the TIC readiness of ECD centres in Zimbabwe, or indeed in southern Africa more broadly, in the context of forced displacement driven by xenophobic violence. This absence is what the present study seeks to address, and it is what motivates both the theoretical framework and the methodological choices described in the sections that follow.

2.5 Theoretical Framework

A theoretical framework is not merely an academic formality. It is the intellectual scaffolding that determines what a researcher sees, what questions they ask and how they make sense of what participants tell them. For a study as contextually specific as this one, the choice of framework had to be guided by three criteria; alignment with the phenomenon under investigation (trauma and institutional readiness), established precedent in related educational research and practical analytical utility for a mixed-methods inquiry situated in a resource-constrained African context. Two frameworks meet these criteria and, importantly, work together in ways that neither could achieve alone. The primary framework is SAMHSA's (2014) four Rs model of trauma-informed care, which provides the substantive content of what TIC readiness means in institutional terms. The complementary framework is Bronfenbrenner's (1979) ecological systems theory, which provides the structural architecture for understanding why TIC readiness may or may not be achievable at different levels of the educational system. Together, they form an integrated analytical lens through which the findings of this study are collected, organised and interpreted.

2.6 SAMHSA's Four Rs Framework of Trauma-Informed Care

SAMHSA's (2014) framework conceptualises trauma-informed care not as a clinical treatment protocol but as a systemic organisational orientation. This distinction is important, especially in a context like Bulawayo's ECD sector, where the absence of mental health professionals makes any clinical framing practically unworkable. The framework holds that any institution, including a school or ECD centre, can become trauma-informed if it reorganises its culture, staff knowledge and operational practices around four core principles. These are Realise, Recognise, Respond and Resist Re-traumatisation.

Realise refers to the broadest level of institutional awareness; the extent to which all staff (not just a designated counsellor) understand that trauma is widespread, that it shapes behaviour and that many of the children they are teaching carry experiences of violence, loss, or disruption that directly affect their functioning in the classroom. Recognise moves from general awareness to practical identification; the capacity to notice the behavioural, emotional and somatic signs that a child may be in a trauma response (withdrawal, aggression, difficulty concentrating, regressive behaviour) rather than simply labelling these as disciplinary problems. Respond refers to the institutional dimension; whether the school's practices, timetabling, disciplinary approaches, physical environment and relationships with families are actively organised to support trauma-affected children rather than inadvertently making things worse. The fourth principle, Resist Re-traumatisation, is perhaps the most demanding; it requires institutions to critically examine their own practices and ask whether anything in their environment might trigger or intensify a child's trauma response, including harsh discipline, public humiliation, or forced participation in activities that activate fear.

Guarino and Chagnon (2018) extended SAMHSA's framework specifically to educational settings, emphasising that the four Rs are not a checklist to complete once but a continuous, reflective institutional process. Cole et al. (2005), whose foundational work on trauma-sensitive schools predates the SAMHSA framework but shares its institutional logic, similarly argued that the transformation of a school into a safe environment for traumatised children requires sustained organisational commitment rather than episodic professional development. In this study, each of the four Rs maps directly onto one of the research questions; educator knowledge and awareness (Realise) is addressed by RQ1; symptom recognition and identification (Recognise) is also addressed through RQ1 and RQ2; institutional response structures and resources (Respond) are examined in RQ2; and the avoidance of re-traumatising practices (Resist Re-traumatisation) is explored across RQ2, RQ3 and RQ4. The framework thus provides both a conceptual vocabulary and an analytical structure that runs consistently through the entire study.

2.7 Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner's (1979) ecological systems theory proposes that human development cannot be adequately understood by examining the child in isolation. Development happens within and is shaped by a set of nested, interacting environmental systems. Each system influences the child either directly or indirectly and changes in any one system have ripple effects across the others. Three of these systems are particularly relevant to this study.

The microsystem is the immediate setting in which the child lives and learns. For displaced ECD learners in Bulawayo, this is the classroom; the daily interactions with educators, the physical environment of the ECD centre, the routines, relationships and emotional tone that the child encounters every morning. This is where TIC readiness (or its absence) is most immediately felt by the child. A classroom where the educator knows how to respond to a trauma symptom is a fundamentally different microsystem from one where the same symptom is punished.

The mesosystem refers to the connections and interactions between different microsystems in the child's life; most critically, the relationship between the ECD centre and the family. For xenophobia-displaced children, this relationship is complicated. Parents are themselves traumatised, unfamiliar with the Zimbabwean education system and may have limited means of engaging with

school staff. Whether ECD centres actively reach out to these families, involve them in their children's settling process and communicate about psychosocial support options matters enormously for the displaced child's recovery.

The exosystem captures the broader institutional and policy environment that shapes what schools can do, even without directly involving the child. National education policy frameworks, ministerial directives (such as the 2026 presidential enrolment directive), funding allocations, educator training curricula and the presence or absence of community mental health services all constitute exosystem factors. They do not sit in the classroom with the child, but they determine, in very concrete ways, whether the educator in that classroom has been trained to respond to trauma, whether there is a counsellor to refer the child to and whether the school's policies create space for trauma-sensitive practice.

Rosa and Tudge (2013), in their revisitation of Bronfenbrenner's later theoretical developments, emphasise that ecological systems theory is not a static model of layered contexts but a dynamic theory of interaction; systems shape each other and the child is not merely a passive recipient of ecological influences but an active participant in shaping the immediate environments they inhabit. This is a useful corrective for any reading of Bronfenbrenner that treats the displaced child purely as a victim of circumstances.

2.8 Integration of the Two Frameworks

The real analytical strength of this study's theoretical foundation lies in how these two frameworks speak to one another. SAMHSA's four Rs tell us what TIC readiness should look like; what knowledge, practices, structures and institutional dispositions need to be in place for a school to be genuinely responsive to traumatised children. Bronfenbrenner's ecological systems theory tells us where to look for the conditions that enable or constrain that readiness; at the level of the classroom (microsystem), the family-school relationship (mesosystem) and the policy and resource environment (exosystem). Separately, each framework addresses only part of the picture. A TIC readiness assessment without an ecological lens risks locating the problem only in individual educator competence, ignoring the systemic conditions that shape what educators can and cannot do. An ecological analysis without TIC's substantive content risks being descriptively rich but normatively empty, describing systems without any clear sense of what a well-functioning response would look like.

Together, the frameworks enable this study to assess TIC preparedness at multiple levels simultaneously. The quantitative strand of the methodology (educator surveys) primarily targets the microsystem dimension, measuring individual educator knowledge and attitudes. The qualitative strand (interviews with educators, administrators and parents) captures mesosystem and exosystem dynamics; how institutional cultures, policy environments and family-school relationships either support or constrain trauma-informed practice. Figure 1 below provides a diagrammatic representation of the integrated framework, showing the four Rs of TIC nested within Bronfenbrenner's ecological layers, with the displaced ECD learner at the centre.

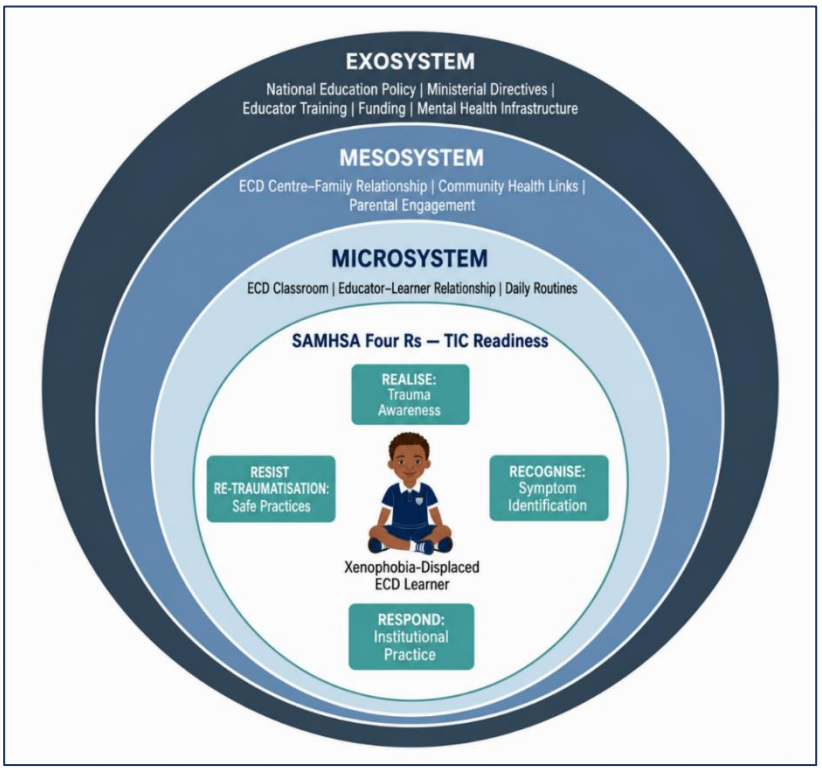


Figure 1. Integrated Theoretical Framework: SAMHSA's Four Rs Within Bronfenbrenner's Ecological Systems Theory (adapted from SAMHSA, 2014; Bronfenbrenner, 1979)

3. Methodology

3.1 Research Paradigm

This study is underpinned by a transformative pragmatist paradigm, which holds that research should not only generate knowledge but actively contribute to the improvement of conditions for marginalised populations; in this case, xenophobia-displaced children and the educators who serve them (Mertens, 2019). Pragmatism, as a philosophical orientation, sits comfortably with mixed-methods inquiry because it refuses the artificial separation between objective and subjective ways of knowing. It accepts that some questions are best answered through numbers (how many educators possess basic trauma knowledge?) while others require the texture of human experience (what does it feel like to teach a five-year-old who wakes up crying from nightmares?). The transformative dimension of the paradigm, drawn from Mertens' (2019) elaboration of the work initially developed by Cresswell and others, adds a normative commitment; the study is not conducted at arm's length from its subjects but with an explicit orientation toward improving their circumstances. In a context where thousands of displaced ECD children are being enrolled into unprepared educational environments, this orientation is not incidental. It is central to the researcher's positioning.

3.2 Research Design

A convergent parallel mixed-methods design is employed, following the specification developed by Creswell and Plano Clark (2018). In this design, the quantitative and qualitative strands are conducted concurrently, analysed separately using techniques appropriate to each type of data and then integrated during the interpretation phase to produce meta-inferences that draw on the strengths of both. The design is well-suited to the study's purpose. Assessing TIC preparedness in Bulawayo's ECD centres requires both breadth (understanding patterns of educator knowledge and institutional readiness across a range of settings) and depth (grasping the lived realities of how educators, administrators and parents encounter psychosocial needs on the ground). Neither a purely quantitative nor a purely qualitative approach could produce the kind of layered understanding this phenomenon demands. Greene (2007) has argued persuasively that mixed-methods designs are most defensible when the research questions themselves call for multiple ways of knowing, which is precisely the situation here.

3.3 Study Site and Setting

The study is conducted in Bulawayo, Zimbabwe's second-largest city and the administrative and cultural centre of the Matabeleland region. Bulawayo has historically served as a major receiving point for Zimbabweans returning from South Africa, given its geographic position, its established Ndebele-speaking population (many of whom have kinship networks across the border) and its role as a transit hub between Beitbridge and the interior. Following the mid-2026 xenophobic uprisings, Bulawayo received a disproportionate share of the returning families, placing sudden pressure on its already strained ECD infrastructure. Ten ECD centres were selected as study sites through stratified purposive sampling to reflect the diversity of institutional types operating in the city; four government ECD centres attached to primary schools, three council-run ECD centres and three registered private ECD centres. Stratification by institution type was essential because these categories differ substantially in staffing ratios, physical resources, educator training levels and administrative oversight, all of which are likely to influence TIC readiness in distinct ways.

3.4 Population and Sampling Strategy

An 80-educator sample was recruited through stratified purposive sampling, with eight educators drawn from each of the ten participating ECD centres. Inclusion criteria required that participants be currently employed as ECD educators at one of the selected centres, currently teaching a class that included at least one xenophobia-displaced learner and have a minimum of one year of teaching experience at ECD level. Exclusion criteria removed relief or substitute teachers (whose exposure to the displaced learners would be limited) and educators on extended leave during the data collection period.

Ten school administrators were purposively selected (one head or deputy head from each participating centre) to provide institutional-level insights into policy, resourcing and enrolment processes. Fifteen parents or guardians of xenophobia-displaced children were recruited through a combination of purposive and snowball sampling, with intentional attention to gender diversity (including male guardians, who are frequently absent from parental engagement research), variation in family structure (single-parent, dual-parent, extended-family arrangements) and range of ECD-age children (three to six years). Sampling continued until data saturation was judged to have been reached across the participant categories.

3.5 Participant Profiles

The final sample composition is summarised in **Table 1**.

Table 1 Summary of Study Participants

Participant Category	Total Number	Recruitment Method	Institution Type Representation
ECD Educators	80	Stratified purposive	32 government; 24 council; 24 private
School Administrators	10	Purposive	4 government; 3 council; 3 private
Parents/Guardians	15	Purposive + snowball	Across all ten centres
Total	**105**		

3.6 Data Collection Instruments and Procedures

A structured questionnaire was adapted from the Attitudes Related to Trauma-Informed Care (ARTIC) scale (Baker et al., 2021), a validated instrument originally developed for use in North American educational settings. Adaptation for the Zimbabwean context involved contextualising item wording to reflect local schooling terminology, translating select items into Ndebele and Shona (with back-translation verification) and adding a set of researcher-developed items specific to the xenophobic displacement context. The final questionnaire measured four constructs; (a) trauma knowledge, (b) trauma symptom recognition skills, (c) perceived self-efficacy in trauma-informed practice and (d) awareness of referral pathways for psychosocial support. All items used a five-point Likert scale (1 = strongly disagree; 5 = strongly agree). The questionnaire was piloted with eight ECD educators at a non-selected centre in Bulawayo. Reliability was assessed using Cronbach's alpha, with a target minimum of $\alpha \geq 0.70$ for each construct; pilot testing yielded alpha coefficients ranging from 0.74 to 0.86 across the four constructs, indicating acceptable to good internal consistency.

Three qualitative instruments were developed for the study. First, a semi-structured interview guide for school administrators focused on institutional policies, enrolment practices, resource allocation for psychosocial support and administrator perceptions of educator preparedness. Second, a semi-structured interview guide for parents and guardians explored the family's displacement experience, the child's post-enrolment adjustment, perceived quality of psychosocial support received from the ECD centre and unmet needs. Third, a focus group discussion guide was prepared for two educator focus groups (eight participants per group), designed to elicit collective reflection on classroom challenges, coping strategies and institutional gaps. All qualitative instruments were reviewed by three subject-matter experts (two educational psychologists and one ECD specialist affiliated with a Zimbabwean university) prior to fieldwork and refinements were made based on their feedback.

Data collection took place over an eight-week period following institutional ethical approval. Questionnaires were administered face-to-face at each participating centre, with the researcher present to clarify items where necessary. Interviews with administrators and parents were conducted in a private space at the ECD centre or at a location of the participant's choosing (usually their home, in the case of parents). All interviews were conducted in the participant's preferred language (English, Ndebele, or Shona) and audio-recorded with consent. Focus group discussions with educators were held on-site at two of the participating centres. Recordings were transcribed verbatim, with non-English content translated into English by a bilingual research assistant and back-checked for accuracy by the researcher.

3.7 Data Analysis Procedures

Questionnaire data were entered into IBM SPSS Statistics version 28 and cleaned prior to analysis. Descriptive statistics (means, standard deviations, frequencies and percentages) were computed to characterise TIC readiness across the sample. Inferential analyses included one-way analysis of variance (ANOVA) to compare mean ARTIC scores across the three institution types (government, council, private), independent samples t-tests where appropriate for two-group comparisons and chi-square tests for categorical comparisons. Where ANOVA revealed significant differences, Tukey post-hoc tests were applied to identify specific between-group contrasts. Effect sizes (eta-squared for ANOVA; Cohen's d for t-tests) were calculated to indicate the magnitude of observed differences. Statistical significance was set at $p \leq 0.05$.

Interview and focus group transcripts were analysed using reflexive thematic analysis, following the six-phase approach developed by Braun and Clarke (2006, 2019); familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. Coding was conducted manually using an initial deductive framework drawn from the SAMHSA four Rs and Bronfenbrenner's ecological systems theory, while remaining open to inductive themes that emerged from the data. NVivo 14 software was used to organise and manage the coded data.

Consistent with convergent parallel design principles, the two strands were integrated at the interpretation stage using a joint display matrix (Guetterman, Fetters, & Creswell, 2015). This matrix arranges quantitative findings alongside corresponding qualitative themes, enabling systematic examination of areas of convergence (where the two data types tell the same story), divergence (where they contradict each other) and complementarity (where each adds a dimension the other cannot capture). The resulting meta-inferences form the analytical backbone of the discussion.

3.8 Trustworthiness

The trustworthiness of the qualitative strand was addressed through Lincoln and Guba's (1985) four criteria. Credibility was strengthened through triangulation across three participant categories (educators, administrators, parents), member checking

with a subset of interviewees who reviewed summaries of their transcripts and prolonged engagement in the field over the eight-week data collection period. Transferability was supported by providing thick description of the study context, participant characteristics and institutional settings, enabling readers to judge applicability to other contexts. Dependability was maintained through a detailed audit trail documenting methodological decisions, coding logic and analytical shifts throughout the study. Confirmability was addressed through a reflexive journal kept by the researcher throughout data collection and analysis, in which assumptions, emotional responses and interpretive choices were recorded and interrogated. For the quantitative strand, reliability was established through pilot testing and Cronbach's alpha analysis and validity was supported through the use of an established scale (ARTIC) adapted with expert review.

3.9 Ethical Considerations

Ethical clearance for the study was obtained from the Midlands state University Ethics Board and permission to access ECD centres was granted by the Ministry of Primary and Secondary Education, the Bulawayo Metropolitan Provincial Education Directorate and the individual school authorities. Written informed consent was obtained from all adult participants prior to data collection, with consent forms provided in English, Ndebele and Shona as appropriate. Participation was voluntary and participants were informed of their right to withdraw at any point without consequence. Confidentiality was assured through the use of participant codes rather than names and all identifying information about specific ECD centres was anonymised in the reporting of findings.

Given the sensitivity of the subject matter, additional ethical safeguards were built into the design. No data were collected directly from children, in accordance with child protection principles for research involving displaced and traumatised populations (Berman et al., 2020). Parents and guardians were informed at the outset of interviews that referral information for community-based psychosocial support services would be provided at the end of the discussion, regardless of whether such support was requested. The researcher underwent psychosocial first aid orientation prior to fieldwork to ensure appropriate handling of any distress that might arise during interviews. All audio recordings, transcripts and data files were stored on password-protected devices, with hard copies kept in a locked cabinet accessible only to the researcher. Data will be retained for five years following publication, in line with standard research data management guidelines, after which they will be securely destroyed.

4. Results and Discussion

The findings are presented across six sub-sections, structured around the SAMHSA four Rs framework and organised in relation to the four research questions guiding the study. Within each sub-section, quantitative survey results are presented first to establish the empirical pattern, followed by qualitative excerpts from educator focus groups, administrator interviews and parent interviews that add texture, contradiction, or explanation to those numbers. A joint display matrix is presented at the end of the section to summarise the integrated findings.

4.1 Educator Knowledge and Realisation of Trauma's Impact (RQ1)

Survey responses on the trauma knowledge construct revealed a striking pattern. Educators demonstrated moderate awareness of trauma as a general concept ($M = 3.34$, $SD = 0.82$ on a five-point scale) but substantially lower confidence in understanding how trauma specifically affects ECD-age children ($M = 2.21$, $SD = 0.94$). This gap between general awareness and developmentally specific knowledge appeared consistently across the sample. One-way ANOVA showed significant differences in trauma knowledge scores across the three institution types [$F(2, 77) = 9.16$, $p = .001$, $\eta^2 = .19$], with private centre educators scoring highest ($M = 3.87$, $SD = 0.71$), followed by council centre educators ($M = 3.28$, $SD = 0.83$) and government centre educators scoring lowest ($M = 2.79$, $SD = 0.88$). Tukey post-hoc analysis confirmed that the difference between private and government centres was statistically significant ($p < .001$).

The qualitative data offered a fuller picture of what those scores meant in practice. Educators across all centre types spoke about trauma in broad, almost lay terms; they understood that the displaced children were suffering, but many struggled to translate that understanding into a workable pedagogical response. One educator captured this tension with unusual clarity:

> *"I know these children have been through bad things. You can see it on their faces, in the way they sit apart from the others. But no one has told us what to do about it. We are teachers, not counsellors and honestly, we are just guessing."* (Educator 12, Government Centre D)

A comparable sentiment was expressed by an educator at a council centre:

> *"When the training came for the new ECD curriculum, no one said anything about trauma. Not one lesson. So when these children came in July, we were meeting them with empty hands."* (Educator 7, Council Centre B)

Private centre educators, by contrast, more frequently referenced formal exposure to trauma content, often through short courses offered by non-governmental organisations. One noted:

> *"We had a two-day workshop through an NGO last year on children and stress. It was not exactly about trauma, but it helped us understand why some children shut down"* (Educator 3, Private Centre A).

This aligns with the quantitative pattern that private centre educators demonstrated the highest levels of trauma-related knowledge.

4.2 Recognition of Trauma Symptoms in Displaced ECD Learners (RQ1 & RQ2)

The symptom recognition construct produced the lowest mean scores of all four constructs on the survey (M = 2.18, SD = 0.91). Only 23.8% of educators reported feeling confident in identifying specific behavioural or somatic signs of trauma in ECD-age children. When asked whether they could distinguish trauma-driven behaviour from ordinary misbehaviour, 61.3% either disagreed or strongly disagreed. Differences across institution types were again significant [$F(2, 77) = 6.42$, $p = .003$, $\eta^2 = .14$], with the same directional pattern favouring private centres.

Qualitative data suggested that while educators observed behaviours consistent with trauma responses (withdrawal, aggression, bedwetting, sleep disturbances during nap time, sudden crying), they often interpreted these through non-trauma frames such as poor upbringing, adjustment difficulties, or family dysfunction. One administrator described a specific case:

> *"We had a little boy who would just start screaming for no reason. The teacher thought maybe he was spoiled at home. It took some time before we realised he was reacting to loud sounds because of what he saw in South Africa. Nobody had taught us to see it that way."* (Administrator 4, Government Centre C)

Parents also spoke about behaviours in their children that they themselves recognised as post-displacement reactions but which they felt were not being properly identified at school:

> *"My daughter, she started wetting the bed again after we came back. She was already six, this had stopped long ago. When I told the teacher, she just said give her time, children are like that. But it is not just being a child, something is broken inside her."* (Parent 9, Council Centre B)

Focus group discussions with educators revealed a recurring theme; the reliance on intuition rather than training. Educators described "sensing" that certain children were struggling but lacking any structured way to confirm or act on this sense. One educator remarked, *"It is like watching someone drown from behind glass. You know they are in trouble, but you do not have the language to name it or the tools to help"* (Educator 15, Focus Group 2).

4.3 Institutional Responses and Psychosocial Support Structures (RQ2)

Institutional response capacity was assessed through both the survey (perceived organisational support subscale) and administrator interviews. The average score for perceived organisational support of trauma-informed practice was M = 2.04 (SD = 0.87), the lowest of any construct measured. Only 12.5% of educators reported that their school had any formal protocol for responding to a child in psychological distress. None of the ten participating centres had a dedicated school counsellor and only two (both private) had a formal referral arrangement with an external mental health provider. **Table 2** presents a summary of institutional TIC infrastructure across the ten centres.

Table 2 Institutional TIC Infrastructure across Participating ECD Centres

TIC Infrastructure Element	Government (n = 4)	Council (n = 3)	Private (n = 3)	Total (n = 10)
Dedicated school counsellor	0	0	0	0
Formal psychosocial policy document	0	0	1	1
External MH referral pathway	0	0	2	2
Designated "safe space" for distressed children	0	1	2	3
Staff trained in psychological first aid	1	1	3	5
Regular staff wellness/debriefing meetings	0	0	2	2

Administrator interviews confirmed the extent of institutional under-preparation. A government centre administrator noted:

> *"The directive from the President said accept all the children and we accepted them. But nobody sent us anything, no counsellor, no additional funding, no guideline document. We are running the same school we ran before, just with more children and heavier problems."* (Administrator 2, Government Centre A)

A council centre administrator described the improvised nature of institutional response:

> *"When a child cries all morning, I take them to my office. I give them water, I let them sit. Sometimes I call the mother. That is my psychosocial support system, me and my office."* (Administrator 6, Council Centre C)

Even at private centres, where the institutional picture was somewhat stronger, administrators expressed serious reservations about the adequacy of what was in place. As one put it: *"We have arrangements on paper, yes. But the*

demand is far beyond what our small team can absorb. We are stretched" (Administrator 8, Private Centre B).

4.4 Avoiding Re-traumatisation: Practices, Policies and Gaps (RQ2)

The fourth SAMHSA principle, resisting re-traumatisation, was assessed indirectly through survey items on disciplinary practices, physical environment and awareness of triggering factors. Only 18.8% of surveyed educators reported having received any training on how classroom practices might inadvertently re-traumatise children. Corporal punishment, though formally prohibited under Zimbabwean law (Constitution of Zimbabwe, 2013), was reported by 34.6% of educators as still occurring "sometimes" or "often" in their school environments, particularly for behaviours that this study's data suggest may in fact be trauma responses.

Focus group discussions produced particularly candid reflections on this issue. One educator observed:

> *"I have seen a colleague slap a child for refusing to line up. That child had come from South Africa two weeks before. I wanted to say something but you know how it is, we do not correct each other openly."* (Educator 21, Focus Group 1)

A parent described a related concern:

> *"My son was punished for being 'stubborn' when the teacher tried to make him sing with the others. He did not want to sing, he was scared. When I asked why he was punished, they said discipline is discipline. But that was not stubbornness, that was fear."* (Parent 4, Government Centre A)

Physical environment factors were also raised. Several administrators noted that overcrowded classrooms, loud playgrounds and the absence of quiet corners meant that children with heightened sensory sensitivity had nowhere to retreat. As one administrator put it: *"There is no space in this school where a child can be alone and calm. Everywhere is noise, everywhere is other children. For a child who is already frightened, that is not a school, that is another crisis"* (Administrator 5, Government Centre D).

4.5 Parents' Perceptions of Psychosocial Support (RQ3)

Parents interviewed for this study presented a picture that was consistent with, but somewhat sharper than, the picture emerging from educators and administrators. Almost all fifteen parents reported that their children had exhibited behavioural or emotional changes following the displacement (nightmares, clinginess, aggression, mutism, regressive behaviours). Only four of the fifteen reported that the school had actively raised these concerns with them and none reported receiving any formal psychosocial support or referral through the school. Parents' perceptions of school responsiveness varied by centre type, with parents whose children attended private centres generally reporting more communicative and attentive engagement.

Several parents expressed a form of resigned appreciation for the school having enrolled their child at all, while acknowledging that enrolment alone did not meet their child's needs:

> *"We are grateful the school took her in. Really, we are. Many places said they were full. But taking her in is one thing, helping her heal is another. That second part, nobody is doing."* (Parent 11, Council Centre A)

Others were more direct in their criticism:

> *"The teacher does not even know my son's story. How can she help him if she does not know what he has been through? Nobody asked us anything when we enrolled. It was just fill this form, bring this money."* (Parent 2, Government Centre B)

A theme that recurred across parent interviews was the sense that the burden of managing their child's psychosocial needs fell almost entirely on the family, often without adequate personal capacity given the parents' own displacement trauma. One mother said:

> *"I am trying to hold my child together while I am also breaking. Who is helping me? The school does its part with the alphabet, but the child inside my child, that is my problem alone."* (Parent 13, Private Centre C)

4.6 Barriers to Trauma-Informed Care Implementation (RQ4)

Educators and administrators identified multiple barriers to TIC implementation. Analysis of the qualitative data produced five recurring barrier themes, presented in Figure 2 as a thematic map and summarised as (a) absence of pre-service and in-service training on trauma; (b) chronic understaffing and high educator-to-learner ratios; (c) lack of dedicated funding for psychosocial support; (d) absence of institutional policy or protocol; and (e) cultural and stigma-related barriers around mental health discussion.

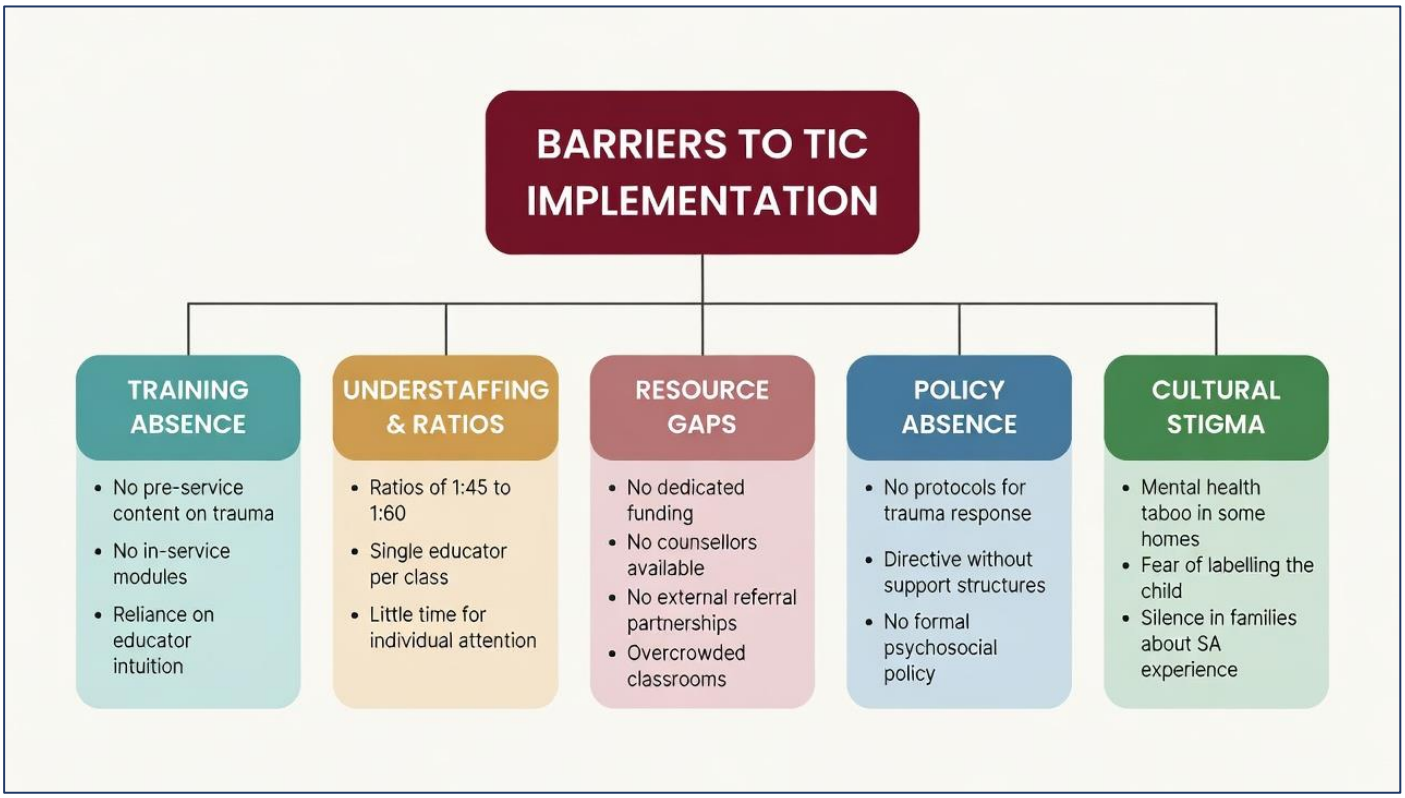


Figure 2 Thematic Map of Barriers to Trauma-Informed Care Implementation in Bulawayo ECD Centres. Note. Developed through reflexive thematic analysis of educator and administrator qualitative data (n = 105).

Educators frequently returned to the training gap as the most immediate barrier:

> *"If they trained us, we would try. We want to help these children. What we lack is not the will, it is the knowledge and the tools."* (Educator 27, Focus Group 2)

Administrators pointed to systemic constraints:

> *"How can I run a trauma-informed school with 380 learners, 8 teachers, no counsellor, no budget line for psychosocial anything and a Ministry that does not even ask me if my staff need support? The math simply does not work."* (Administrator 9, Council Centre A)

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A subtler barrier that appeared in several parent interviews related to cultural silence around traumatic experience. Two parents mentioned that they had not told the school what had happened in South Africa because they did not want their children to be "marked" or "gossiped about" by other parents. This suggests that even where institutional structures might be adequate, cultural and interpersonal factors could still impede access.

4.7 Integrated Joint Display Summary

Table 3 presents a joint display integrating the quantitative and qualitative findings across the four SAMHSA domains

Table 3 Joint Display of Quantitative and Qualitative Findings by SAMHSA Domain

SAMHSA Domain	Quantitative Finding	Qualitative Theme	Integration Type
Realise	M = 3.34 general awareness; M = 2.21 ECD-specific	Educators aware of trauma broadly; struggle to specify ECD manifestations	Convergent
Recognise	M = 2.18; only 23.8% confident in symptom ID	Reliance on intuition; misinterpretation of trauma as misbehaviour	Convergent
Respond	M = 2.04 org. support; 0/10 centres with counsellors	Improvised individual responses; no institutional infrastructure	Convergent
Resist Re-traumatisation	18.8% trained; 34.6% report ongoing corporal punishment	Punishment of trauma responses; environmental triggers unaddressed	Convergent

Institution Type Comparison	Private > Council > Government across all constructs	Private centres reference NGO training; government centres report zero training	Convergent
Parent Perspective	Not measured quantitatively	Grateful for enrolment; feel psychosocial burden falls on family	Complementary

The overall pattern across the six sub-sections shows strong convergence between quantitative and qualitative findings, with parent perspectives adding a complementary dimension that the educator survey alone could not capture. Interpretation of these findings, along with their theoretical and practical implications, is presented in the discussion section that follows.

4.8 Discussion

This study set out to assess the preparedness of Bulawayo's ECD centres to provide trauma-informed care to children displaced by the mid-2026 xenophobic uprisings in South Africa, drawing on the perspectives of educators, administrators and parents. What emerged from the findings is a picture that is both unsurprising in its broad contours and troubling in its specific detail. Bulawayo's ECD centres, at every institutional level, are not currently equipped, in terms of educator knowledge, institutional structures, resource allocation, or policy scaffolding, to respond meaningfully to the psychosocial needs of the children who have been placed in their care. The discussion that follows moves through the major findings, interprets them through the SAMHSA and Bronfenbrenner frameworks that anchor the study and situates them within the broader scholarly conversation on trauma-informed education, ECD in African contexts and forced displacement.

4.8.1 The Awareness–Competency Gap: Understanding without the Means to Act

Perhaps the most consistent pattern across the survey and interview data was the disjunction between educators' general awareness of trauma and their practical capacity to identify, respond to, or manage trauma-related presentations in the classroom. Educators knew, in a general sense, that the displaced children in their care had endured difficult experiences. They could speak about "bad things," "what happened in South Africa," and "children who are hurting." What they could not do, with any consistency, was translate that awareness into structured, developmentally informed practice. Read through the SAMHSA (2014) four Rs, this represents a break in the sequence between "Realise" and "Recognise"; the first domain is partially satisfied, but the second is largely absent and without both, the subsequent domains ("Respond" and "Resist Re-traumatisation") cannot function.

This finding is not new in the international TIC literature. Dorado et al. (2016), in their evaluation of the HEARTS programme, arrived at a similar conclusion; single-session or short-course awareness training rarely produces the kind of skill development required for genuine recognition of trauma presentations in children. Thomas et al. (2019) reached the same conclusion across their review of two decades of TIC school interventions, arguing that awareness without practice-based skill building is one of the most common failure points of TIC implementation efforts. What the Bulawayo data add to this conversation is the observation that in the sub-Saharan African context, even the awareness half of the equation is fragile, sustained by educators' personal empathy rather than by any structured training. Educators are, in effect, drawing water from a well they were never taught to dig.

Viewed ecologically, following Bronfenbrenner (1979), the gap becomes easier to explain. Educators sit within a microsystem (the classroom) whose functioning is directly shaped by exosystemic factors over which they have no control. Pre-service ECD training curricula in Zimbabwe do not include modules on childhood trauma (Ministry of Primary and Secondary Education, 2016). In-service professional development on psychosocial support is essentially absent from the Ministry's regular offerings. The educator who is expected to recognise a trauma symptom in a four-year-old has never been shown what such a symptom looks like, nor given any framework for interpreting it. Ncube and Tshabalala (2022) documented this training gap in their examination of ECD implementation in Zimbabwean primary schools, finding that ECD educator preparation focuses almost exclusively on cognitive and physical development, with socio-emotional and psychosocial content receiving only cursory attention. The Bulawayo findings extend this observation into the specific domain of trauma response, showing that when a crisis event arrives, the training infrastructure is not merely inadequate; it is essentially non-existent.

4.8.2 Institution Type as a Proxy for Access: The Private Centre Advantage

One of the more striking quantitative findings was the consistent advantage of private ECD centres over council and government centres across every SAMHSA domain measured. Private centre educators scored significantly higher on trauma knowledge, symptom recognition, self-efficacy and awareness of referral pathways. The temptation is to read this as evidence that privatisation produces better psychosocial outcomes; a reading that would be both simplistic and, in this study's view, mistaken. The qualitative data suggest a more textured explanation.

Private centre educators repeatedly referenced training received through non-governmental organisations, international donor-funded workshops and short courses

offered by mental health foundations operating in Bulawayo. Government centre educators, when asked about training exposure, consistently reported none. The pattern that emerges is not one of private sector superiority in TIC per se, but of differential access to a training and resource ecosystem that operates largely outside the state education system. This aligns with the observations of Mugweni and Dakwa (2013) and Chikwiri and Musiyiwa (2017), who noted that Zimbabwe's ECD sector operates as a two-tier structure, with private centres benefiting from external partnerships and resource injections that government centres cannot access. The implication is important: the private centre "advantage" documented in this study is not a sustainable model, because it depends on charitable and philanthropic inputs that are geographically and organisationally uneven. Children in government centres, who are already the majority of the displaced learner population, are being served by educators whose access to any form of TIC preparation is essentially zero.

Interpreted through Bronfenbrenner's ecological framework, this pattern reflects mesosystem asymmetry. Private centres have functional connections between their institutional microsystem and the wider community mental health and training ecosystem. Government centres, structurally embedded within a Ministry that itself has not prioritised psychosocial support in ECD, lack those mesosystem bridges. This is not a criticism of individual educators. It is a description of how ecological positioning shapes what is possible within the classroom, regardless of the educator's personal will or capability.

4.8.3 The Silence on Re-traumatisation: An Uncomfortable Finding

One of the more difficult findings to sit with was the observation that corporal punishment continues to occur in a substantial minority of the surveyed ECD environments, despite its formal legal prohibition and that some of this punishment appears to be directed at behaviours that are themselves trauma responses. This finding is uncomfortable because it complicates the narrative of well-intentioned educators simply lacking resources. It suggests that at times, the practices in place are actively producing harm rather than merely failing to produce healing.

Berger and Martin (2021), in their review of TIC in schools, argued that resisting re-traumatisation is the most demanding of the SAMHSA principles because it requires institutions to critically examine their own routine practices rather than simply add new ones. This is precisely what the Bulawayo data suggest is not happening. Punishment for "stubbornness" that is in fact trauma-driven withdrawal, verbal reprimand for behaviours that reflect hyperarousal and the physical environment of overcrowded classrooms with no quiet spaces for self-regulation, all constitute forms of institutional re-traumatisation that current ECD practice in Bulawayo does not name, recognise, or interrupt. Venet's (2021) critique of TIC becomes relevant here; it is not enough to build children's resilience if the structures around them continue to generate the very stressors that require resilience in the first place. A trauma-informed centre cannot coexist with routine corporal punishment. The two are logically and practically incompatible.

4.8.4 The Parental Voice: Gratitude, Frustration and Structural Isolation

The parent interviews produced a set of themes that were not fully anticipated at the design stage. Parents expressed a form of resigned gratitude for the fact that their children had been accepted into schools at all, a gratitude that seemed to coexist uncomfortably with sharp frustration at the inadequacy of psychosocial support and, more strikingly, with a strong sense that the burden of managing their child's trauma fell entirely on the family. This last observation warrants closer examination.

Bourdieu's (1986) framework of social capital offers a useful interpretive lens here. In resource-poor institutional environments, families rely heavily on informal social capital, kinship networks, church communities, neighbours, other returnee families, to fill the gaps left by absent institutional support. Several parents in this study described drawing more comfort and practical guidance from other displaced parents than from the schools their children attended. This is consistent with findings from other African migration studies (Chikanda & Crush, 2023) showing that returnee families construct dense informal support networks precisely because formal services fail them. What is worrying, from a TIC perspective, is that these informal networks, while genuinely valuable, cannot substitute for the specialised psychosocial support that traumatised children require. A neighbour who has also fled xenophobic violence can offer solidarity, but not therapeutic intervention. When institutions abdicate responsibility, families do their best. But their best is often not enough and they know it.

Read ecologically, the finding illustrates a broken mesosystem. In a functional TIC ecosystem, the ECD centre and the family would communicate regularly about the child's psychosocial state, share observations, coordinate approaches and jointly access external support where needed. The Bulawayo data suggest that this coordination is almost entirely absent. Enrolment is transactional. Ongoing communication is minimal. Referral pathways do not exist. The parent and the educator are, in effect, working on opposite sides of a wall neither of them built.

4.8.5 The Presidential Directive and the Limits of Political Will

The 2026 presidential directive that no returning child should be denied enrolment (The Herald, 2026) is worth revisiting in light of the findings. The directive was politically necessary and, in the most immediate sense, effective; schools opened their doors and children were enrolled. What the findings show is that the directive stopped there. Enrolment was mandated. Support was not. Funding was not adjusted. Educator training was not

initiated. Referral partnerships with mental health services were not established. Policy documents were not amended. The directive functioned as what education policy scholars have described as a symbolic policy instrument (Cairney, 2020); an intervention that establishes political commitment without altering the operational infrastructure required to fulfil that commitment.

This is not unique to Zimbabwe. Dryden-Peterson (2016) documented similar dynamics in refugee education contexts globally, where enrolment mandates routinely outrun the capacity of receiving institutions to provide meaningful educational experiences to displaced children. What the Bulawayo case adds is a specific illustration of how, even in an intra-national return context (rather than a cross-border refugee context), the enrolment–support gap manifests in ways that leave both children and educators exposed. The directive placed children in classrooms. What happens inside those classrooms is another question and the directive did not answer it.

4.9 Contribution to Theory, Practice and Policy

Several contributions emerge from this study. Theoretically, the research extends the SAMHSA four Rs framework into a sub-Saharan African ECD context for what appears to be the first empirical application of its kind. The extension is not straightforward. The framework, developed in contexts with functional mental health referral systems, presupposes infrastructure that does not exist in most Bulawayo ECD environments. This study suggests that a fully operational adaptation of TIC for African ECD contexts must either accept significant modification of the "Respond" domain (to reflect the reality of absent formal referral pathways) or, alternatively, be paired with sustained investment in building the community mental health infrastructure that would make full TIC implementation possible. The current framework, imported unmodified, risks producing institutional performances of TIC that do not deliver its substantive benefits.

The integration of Bronfenbrenner's ecological systems theory with the SAMHSA framework proved analytically productive in ways that neither framework could achieve alone. The four Rs described what TIC readiness should look like. The ecological lens explained why that readiness is unevenly distributed across Bulawayo's ECD landscape, tying microsystem realities to mesosystem gaps and exosystemic policy failures. Future research on TIC in resource-constrained African contexts could benefit from a similar dual-framework approach.

Practically, the study provides an evidence base for the design of contextually adapted TIC training modules for Zimbabwean ECD educators. The consistent finding that educator willingness is not the barrier (educators want to help; they lack the tools) suggests that even modest, well-designed training interventions could produce meaningful shifts in classroom practice. Policy-wise, the study makes a strong case for revising the Ministry of Primary and Secondary Education's (2016) National ECD Policy to include explicit provisions for psychosocial support, trauma-informed practice and referral pathways and for coupling any future enrolment directives (whether in response to xenophobia or other displacement crises) with the operational and financial support necessary to convert political commitment into pedagogical reality.

The children who arrived in Bulawayo's ECD centres in the second half of 2026 did not need a policy pronouncement. They needed classrooms prepared to hold their fear, recognise their distress and respond to their needs with skill and care. Whether such classrooms exist is a question this study has answered clearly and the answer, for now, is not what any of us would want it to be.

4.10 Implications

4.10.1 Implications for ECD Practice

The findings point toward several practical shifts that ECD educators and centre administrators in Bulawayo could begin implementing without waiting for national policy reform. The consistent gap between educators' willingness to help and their capacity to identify trauma responses suggests an immediate need for a Zimbabwean ECD Trauma Recognition Toolkit; a culturally contextualised, illustrated guide that helps educators distinguish trauma-driven behaviours (such as sudden aggression, prolonged withdrawal, selective mutism, regressive bedwetting, or startle responses to loud sounds) from what is often misread as wilful misconduct or "spoiled child" behaviour. Such a toolkit would need to be developed in English, Ndebele and Shona and grounded in examples drawn from the actual behavioural presentations reported by Bulawayo educators in this study. It would function not as an academic manual but as a practical bedside reference that educators can consult when a child's behaviour puzzles or troubles them.

Building on this recognition capacity, ECD centres should integrate low-cost, evidence-based classroom practices that support emotional regulation without requiring specialist personnel or costly resources. Jennings (2019) has demonstrated the value of structured buddy systems, in which each child (particularly a newly enrolled displaced child) is paired with a peer for the first several weeks of school; and daily emotional check-in routines during circle time, in which children are invited to indicate their emotional state through simple visual prompts (a face chart, coloured cards). These practices are within the reach of any ECD classroom, regardless of resource level and their consistent application would represent a meaningful practical advance on the current situation.

Beyond the classroom, each participating centre would benefit from the formalisation of a designated pastoral care role. Given that no school in the sample had a dedicated counsellor, this role could realistically be occupied by a trained community health worker, a retired teacher with additional psychosocial training, or a senior educator granted release time to focus specifically on the psychosocial wellbeing of displaced learners. The

pastoral care role would provide a first point of contact for children in distress, coordinate communication with parents and maintain a simple register of children who may require external referral if and when such services become available.

4.10.2 Implications for Education Policy

Policy implications must be addressed at three interlocking levels; the institutional (school), the metropolitan and the national. At the institutional level, each ECD centre should be required to develop a formal psychosocial support policy document, however brief, that specifies referral pathways (even where these are informal or NGO-based), designates a safe space within the school for children in distress and establishes trauma response protocols for common presentations. The current situation, in which almost every centre operates on ad hoc arrangements, produces inconsistency and leaves both children and staff exposed. A one-page written protocol, developed and displayed, would represent a significant institutional step forward.

At the metropolitan level, the Bulawayo Metropolitan Provincial Education Directorate should consider establishing a roving ECD psychosocial support team; a small unit of educational psychologists, trained counsellors and social workers that circulates across clusters of ECD centres on a scheduled basis. This model, adapted from the mobile school support unit approaches piloted in other African contexts (Berger, 2019), would allow specialist input to reach schools that cannot individually afford or attract permanent counsellors. The unit would also serve as a referral resource for the pastoral care leads within each centre, providing supervision, case consultation and direct assessment of children in acute distress.

At the national level, three actions from the Ministry of Primary and Secondary Education would represent meaningful reform. First, revision of the pre-service and in-service ECD educator training curricula to include a mandatory module on trauma-informed pedagogy, developmentally appropriate psychosocial support and recognition of complex trauma presentations in young children. Second, development of a National Trauma-Informed Care Framework for ECD that is culturally adapted to Zimbabwean realities, including the country's specific patterns of displacement (economic migration, xenophobic return, climate-driven relocation) rather than simply importing Western TIC models. Third, formal inter-ministerial coordination between the Ministry of Primary and Secondary Education and the Ministry of Public Service, Labour and Social Welfare, to ensure that school-based psychosocial support is genuinely connected to community mental health infrastructure rather than existing as an isolated educational initiative. Future enrolment directives, whether in response to xenophobic events or other displacement crises, must be accompanied by operational support packages that make their implementation genuinely possible.

4.10.3 Implications for Research

Three areas of future research emerge from the present study. First, longitudinal studies are needed to track the academic, developmental and psychosocial trajectories of xenophobia-displaced children over time as they progress through the Zimbabwean education system. The present study captured a specific moment in the immediate aftermath of displacement; what happens to these children over the following three, five, or ten years remains an open and important question. Second, intervention research is needed to test the effectiveness of culturally adapted TIC training programmes for Zimbabwean ECD educators. The findings of this study identify the gap; a natural next step is the design and rigorous evaluation of interventions that seek to close it. Third, comparative studies across Zimbabwean cities (Harare, Mutare, Gweru) would help to establish whether the TIC readiness patterns documented in Bulawayo are generalisable to the national ECD landscape or reflect particularities of the Bulawayo context. Such comparative work would provide the empirical basis for evidence-informed national policy reform.

4.11 Limitations of the Study

Several limitations of the present study deserve honest acknowledgement, each accompanied by a brief note on how it was mitigated or how it might be addressed in future research. The qualitative findings of the study are not statistically generalisable to all Zimbabwean ECD contexts and the sample of ten ECD centres in a single city cannot represent the full diversity of ECD provision across the country. Following Yin's (2018) argument for analytic generalisability, however, the findings are generalisable to theory rather than to population; the study contributes to how we understand TIC readiness in resource-constrained ECD contexts and the theoretical insights are transferable even where the empirical particulars are not. The stratified purposive sampling across three institution types provided variation within the sample that strengthens the analytic value of the findings.

Educator self-reports on the ARTIC scale are potentially vulnerable to social desirability bias, particularly in a professional context where educators may wish to present themselves as competent and caring. This limitation was partially mitigated by the triangulation of survey data with focus group discussions and administrator interviews, which provided independent perspectives on educator preparedness. Where the three data sources converged (as they largely did), confidence in the findings is strengthened; where they diverged, the divergences themselves became analytically informative.

The study did not collect data directly from the displaced children, in line with ethical protocols for research involving children in acute post-trauma states (Berman et al., 2020). This means that the study captures the perspectives of the adults around these children (educators, administrators, parents) rather than the children's own voices. This is a genuine limitation and future research, conducted at a greater temporal distance from the traumatic events and with appropriate child-centred methodological safeguards, could helpfully centre

children's own accounts of their educational and psychosocial experiences.

The study is temporally specific, conducted in the months immediately following the mid-2026 xenophobic uprisings. Institutional capacity, policy responses and community adaptations may well evolve over time and the findings should be read as a snapshot of a particular crisis moment rather than a permanent description of Bulawayo's ECD landscape. Repeat studies at intervals of one, three and five years would help to trace how (and whether) the current inadequacies are addressed over time.

5. Conclusion and recommendations

5.1 Conclusion

The forced return of Zimbabwean families following the mid-2026 xenophobic uprisings in South Africa created an unprecedented psychosocial emergency within Bulawayo's Early Childhood Development (ECD) sector. This study assessed the preparedness of Bulawayo's ECD centres to provide trauma-informed care (TIC) to displaced learners, integrating perspectives from educators, administrators and parents across government, council and private institutions.

The findings demonstrate a systemic structural unpreparedness across Bulawayo's ECD infrastructure. While educators display high baseline empathy and general awareness of trauma, a critical gap exists between general awareness and practical competency. Educators consistently lack the skills to recognize childhood trauma manifestations, often misinterpreting neurological distress signals as behavioral non-compliance. At an institutional level, psychosocial support infrastructure is virtually absent: none of the sampled centres employ qualified counsellors, referral pathways to specialized mental health services are non-existent in public institutions and punitive disciplinary actions (including illegal corporal punishment) persist in a notable minority of settings, posing severe risks of re-traumatization. Furthermore, the performance advantage observed in private centres reflects unequal reliance on non-governmental training resources rather than state-driven systemic capacity.

Theoretically, the study extends SAMHSA's four Rs framework into a resource-constrained African educational context, demonstrating that the framework's operationalization requires structural policy scaffolding and mesosystemic integration (Bronfenbrenner, 1979) to be viable. Empirically, the study proves that presidential enrolment directives, while necessary to guarantee the right to education, are fundamentally insufficient unless accompanied by structural investments in psychosocial support. Opening classroom doors without equipping educators to handle trauma creates an environment of performative integration, leaving traumatized children, overburdened educators and isolated families to navigate developmental recovery without adequate institutional scaffolding.

5.2 Recommendations

Based on the empirical and qualitative findings of this study, the following prioritised recommendations are proposed:

Recommendations for Practice and School Administration

1. Develop and Deploy a Contextualized ECD Trauma Recognition Toolkit: The Ministry of Primary and Secondary Education (MoPSE), in collaboration with educational psychologists, should develop a practical, tri-lingual (English, Ndebele, Shona) diagnostic toolkit to assist ECD educators in differentiating complex trauma symptoms (e.g., hyperarousal, withdrawal, regression) from routine behavioural misbehaviour.
2. Establish School-Level Pastoral Care and Emotional Regulation Spaces: ECD centre administrators should designate trained senior educators or community health liaisons as lead pastoral care facilitators, while creating low-cost sensory quiet corners within classrooms to support children experiencing emotional dysregulation.
3. Institute Mandatory Non-Punitive Disciplinary Protocols: School leadership must enforce zero-tolerance policies regarding corporal punishment and conduct internal audits to eliminate disciplinary practices that trigger re-traumatization among displaced learners.

Recommendations for Educational Policy and Governance

1. Integrate Trauma-Informed Care into National ECD Policy: MoPSE should formally amend the National Early Childhood Development Policy (2016) and the Education Amendment Act (2020) to explicitly mandate trauma-informed pedagogy, psychosocial first aid and emotional well-being indicators alongside academic benchmarks.
2. Reform Pre-Service and In-Service Educator Training Curricula: Teacher training colleges and universities must incorporate compulsory modules on neurodevelopmental trauma, crisis intervention and psychosocial support into standard ECD diploma and degree programmes.
3. Establish Metropolitan Roving Psychosocial Support Teams: The Bulawayo Metropolitan Provincial Education Directorate should construct mobile units composed of educational psychologists and social workers to provide rotational assessment, teacher supervision and clinical referral services across public ECD clusters.
4. Formalize Inter-Ministerial Displacement Protocols: Future emergency enrolment directives issued by the executive branch must be coupled with inter-ministerial operational funding (linking MoPSE with the Ministry of Public Service, Labour and Social Welfare) to ensure mandatory health, nutritional and psychological support accompanies physical school admission.

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