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Multidisciplinary models of care

Strengthening services for child victims and survivors of sexual abuse and exploitation in the digital age

Safe Online



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Acronyms

CSO	Civil society organization
NPA	National Prosecuting Authority (South Africa)
NGO	Non-government organization
RoLAC	Rule of Law and Anti-Corruption Programme (Nigeria)
SAPI	Social Activities and Practices Institute (Bulgaria)
SARC	Sexual Assault Referral Centre (Nigeria)
TCC	Thuthuzela Care Centre (South Africa)
UNICEF	United Nations Children's Fund
WCPU	Women and Children Protection Unit (The Philippines)

1. Key learnings and recommendations

KEY LEARNING 1

Multidisciplinary service integration succeeds when relationships, systems design and legal mandates work together.

Physical co-location alone does not guarantee integrated services for children. Integration emerges when institutional structures are paired with strong relationships across sectors. Because sectors have different cultures and ways of working, integration requires deliberate planning, clear legal mandates, and robust interagency protocols and procedures.

Opportunities and way forward:

- **Strengthen cross-sector relationships.** Prioritise targeted outreach with courts, law enforcement, health, education and other key sectors to build trust, clarify roles, and improve understanding of the multidisciplinary model for supporting children.
- **Use co-location strategically.** Use co-location for services requiring immediate coordination (such as law enforcement, social services, health, and psychosocial support), while linking other services (such as longer-term counselling and medical care) through formal referral agreements and joint case management.
- **Institutionalise regular coordination.** Establish routine coordination mechanisms, including regular meetings, joint case conferences and shared interviews, to strengthen cross-team understanding and collaboration. These should be institutionalized at both technical and policy levels to ensure sustained alignment of priorities and procedures.
- **Embed integration in systems.** Sustain coordination through joint protocols, interagency training, supportive supervision and accountability systems, with explicit budget allocations.
- **Close gaps in specialized support.** Build capacity to support children displaying harmful behaviours, ensure ongoing mental health services beyond crisis intervention, and establish feedback loops for external referrals.

KEY LEARNING 2

Dedicated effort is required to ensure multidisciplinary services can effectively support child victims of technology-facilitated sexual abuse and exploitation.

Multidisciplinary service providers are increasingly encountering cases of technology-facilitated abuse, yet stakeholders report that this issue is not being systematically identified or addressed by services. Services designed to respond to cases of in-person abuse face challenges in managing cases of technology-facilitated abuse due to the unique characteristics of these crimes and their impact on children. Protocols and procedures need adaptation to address technology-facilitated abuse. Frontline service providers want to better understand this issue and offer more effective care and services for children.

Opportunities and way forward:

- **Build multidisciplinary service capacity to address technology-facilitated abuse.** This includes ongoing professional development and adaptation of existing protocols for forensic interviews, crisis interventions, psychosocial interventions, and interagency case management and referral pathways.
- **Ensure children identified by law enforcement can access multidisciplinary support.** Improve pathways from law enforcement, often the first point of contact in cases of technology-facilitated abuse, to connect children with psychosocial, therapeutic and other care they need.
- **Incorporate questions about technology-facilitated abuse into intake protocols.** Collecting information on technology use and online interactions can provide valuable information to support children effectively. This must be done carefully to avoid inadvertent victim-blaming.

KEY LEARNING 3

Embedding multidisciplinary models into national and sub-national child protection systems can help ensure services are accessible to all children nationwide.

Once a multidisciplinary service model demonstrates effectiveness and scalability, it should be formally embedded in the national child protection system so it can become legally mandated, structured and resourced. Services should be accessible on an equitable basis to the whole population. This requires an affordable way of scaling models across all subnational administrative units, ideally supported by public funding. The shift toward government ownership should be planned from the outset, including a phased transition strategy and a clear financial plan. Providing stakeholders with clear information on how multidisciplinary approaches align with existing policies and institutional regulations will help facilitate understanding, ownership and long-term sustainability.

Opportunities and way forward:

- **Document challenges and opportunities to inform future action.** Comprehensive documentation of how models function in practice and observed outcomes can support effective scale-up. Country-level insights help identify what works in specific contexts, while global evidence highlights shared challenges and opportunities that can guide future policy and practice.
- **Prioritise integration into government budgets.** Through investment case analysis, governments can evaluate costs, outcomes, and long-term affordability to enable evidence-based decisions about allocating limited resources to models that deliver the greatest social and economic return.
- **Clarify and strengthen roles of government and NGO partners.** Partnership models can position NGOs to provide flexibility, innovation, and specialized skills, while government provides oversight, coordination, infrastructure, and sustainability. These arrangements should be formalized through agreements with clear roles and stable funding mechanisms.

KEY LEARNING 4

Reflecting children and community voices can make multidisciplinary services more relevant, trusted and accessible.

Children have a right to be heard in matters affecting them and their insights, alongside those of families and communities, improve cultural relevance, accessibility, and child-friendliness of services. Participation should be integral to model design and improvement, not an afterthought. Community connections also strengthen early identification, build trust in reporting and support children in familiar environments.

Opportunities and way forward:

- **Ensure opportunities for children and adolescents to share their views.** Children and adolescents can be ethically and safely involved in service design in ways that respect their voices and guide policy without causing harm. Participatory methods include creative approaches such as art, play and storytelling, as well as structured, yet flexible interview techniques adapted to the child's age and cognitive abilities.
- **Reflect child and adolescent views in case planning and system design.** Feedback and complaint mechanisms should be age-appropriate and designed to avoid retraumatization, allowing children to safely express their views on their care as well as on service improvement.
- **Ensure services are equally accessible to all children and families.** Services should be made available to all children and at no cost to children and their caregivers. Conducting outreach to marginalized groups and culturally adapting services in consultation with community leaders can support efforts to improve the accessibility and appropriateness of services, especially for the most vulnerable.

KEY LEARNING 5

Strong staff support systems are critical for sustaining quality multidisciplinary services.

Multidisciplinary model staff are managing heavy caseloads, which can lead to delays, quality pressures, burnout and high turnover. When staff are overwhelmed, interagency coordination becomes harder to sustain. Psychosocial care providers carry particularly heavy emotional demands without always having access to adequate support systems. This is a challenge across all child protection services and is not unique to multidisciplinary models.

Opportunities and way forward:

- **Build staff support services into standard practice.** This should include psychological supervision, peer support groups, stress management and regular debriefing. Support can extend to government staff, including police, prosecutors and social workers, who often do not have access to such programmes.
- **Ensure realistic workloads and avoid overburdening frontline staff.** Systematic assessment of staffing needs can inform recruitment to achieve better ratios between staff and caseloads.
- **Establish regional and global communities of practice.** Explore opportunities to facilitate learning exchanges and establish platforms for frontline service providers to collaboratively develop and apply evidence-based strategies for identifying and effectively responding to emerging and complex challenges, including technology-facilitated abuse.

KEY LEARNING 6

Monitoring and evaluation can strengthen the delivery of a specialized child-centred approach.

While most multidisciplinary models track key operational information, the study identified a critical need to shift from data collection designed for donor accountability to practices that directly inform service quality improvements and contribute to improving delivery of a specialized child-centred approach. Monitoring systems can evolve to measure outcomes that matter to children and families while also serving practitioners' immediate needs for case management and coordination. This dual-purpose design would be more sustainable than systems that only serve external reporting requirements. With intentional design, monitoring systems can become genuine learning platforms that inform innovation, strengthen service delivery, and improve outcomes for children.

Opportunities and way forward:

- **Capture child-centred information and outcomes that support long-term recovery.** Multidisciplinary models, including those that serve both women and children, should include child-specific indicators, such as reduction in trauma symptoms and revictimization, and systematically collect monitoring data such as parent and child feedback on the quality of care and longer-term outcomes for children and families. This requires adequate evaluation planning, staffing, user-friendly data tools and survivor-centred longitudinal follow-up approaches.
- **Design systems to collect information for ongoing adaptation.** Case management and monitoring systems should routinely capture operational data, including service utilization patterns, case processing times, frontline staff observations and emerging forms of harm such as technology facilitated abuse, to support rapid learning and refinement. Structured review processes, supported by senior leadership and technical peers, can ensure that evidence is translated into timely adjustments in practice.
- **Involve children and adolescents in evaluations and learning.** Develop child and adolescent friendly evaluation tools that enable meaningful input on the quality and safety of care received, their experience of multidisciplinary services, and risks they encounter, including technology facilitated abuse. These insights should inform both individual case planning and broader service design.
- **Invest in ongoing analysis of emerging trends and service performance.** Regular review of administrative data helps ensure services remain responsive and effective. This requires dedicated analytical capacity and mechanisms to integrate findings into operational and policy decisions.

Multidisciplinary models function within broader child protection systems that often face resource shortages, capacity limitations, and structural gaps. Challenges should therefore be interpreted with these contextual factors in mind, rather than attributed solely to the model's design or implementation.

2. Background

When children have suffered abuse, they have a right to access services that support healing, protection, and justice.[1] This requires coordinated contributions from practitioners from multiple specialized disciplines including police investigators, prosecutors, social workers, medical professionals and psychologists. When these services are fragmented, they risk impeding access to care and justice, may lead to secondary traumatization, and fail to effectively mitigate long-term harm. Bringing these disciplines together in an integrated model can result in both efficiencies in service delivery and better outcomes through adopting a child-centred approach.

While evidence on the design and effectiveness of child-centred multi-disciplinary models is growing, and such models are increasingly being implemented globally, significant gaps remain. Research is particularly limited in lower-income settings, and even more so regarding how these models respond to the needs of children and adolescents whose experiences of exploitation and abuse include a digital component.

This report builds on the earlier publication *Multidisciplinary models of care for Child Victims and Survivors of Sexual Abuse and Exploitation in the Digital Age: A rapid review of the literature on child-centred services responding to in-person and technology-facilitated abuse*.[2] That review synthesized peer-reviewed and grey literature to provide an overview of prominent multidisciplinary models, identify lessons learned, and inform fieldwork in four countries (Bulgaria, Nigeria, the Philippines, and South Africa). The four countries were intentionally selected taking into account the existence of a well-developed multidisciplinary service model, varied regional and socio-economic contexts, and the demonstrated interest and capacity of UNICEF and national partners to engage with and act upon the research findings.

The present report brings together key findings from that fieldwork, alongside insights from the literature review, to offer actionable recommendations for policymakers and practitioners.

1. This obligation stems from Article 2.3 of the International Covenant on Civil and Political Rights, which applies to all human beings including children, and establishes that any person whose rights or freedoms are violated has a right to an effective remedy. Further, Article 39 of the Convention on the Rights of the Child requires States to 'take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim' of any form of exploitation or abuse and that such recovery and reintegration should 'take place in an environment which fosters the health, self-respect and dignity of the child'. See also: Article 9.3 of the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, which provides that States 'shall take all feasible measures with the aim of ensuring all appropriate assistance to victims … including their full social reintegration and their full physical and psychological recovery' as well as the UN Committee on the Rights of the Child, Guidelines regarding the implementation of the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography, UN Doc CRC/C156, 10 September 2019. Available at: https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crcc156-guidelines-regarding-implementation-optional.
2. United Nations Children's Fund, 'Multidisciplinary models of care for Child Victims and Survivors of Sexual Abuse and Exploitation in the Digital Age: A rapid review of the literature on child-centred services responding to in-person and technology-facilitated abuse', UNICEF, New York, March 2025. Available at: https://www.unicef.org/documents/multidisciplinary-models-care-child-victims-and-survivors-sexual-abuse-and-exploitation.

2.1 Methodology

Following the rapid global literature review, the Research Team developed a research methodology for the country visits informed by the guidance of an expert Reference Group. The methodology underwent ethical review by the Health Media Lab Institutional Review Board and received approval in April 2025. It was then piloted in Bulgaria, where initial interviews with national stakeholders and a review of country-level documentation helped refine the data collection approach, with particular attention to model functioning, available services, and the roles of different service providers.

Data collection was conducted on-site in two locations each in Bulgaria and the Philippines, and in one location in Nigeria and South Africa. An online survey of frontline service providers supported triangulation of qualitative data gathered through interviews and focus groups. Country-level findings were then validated through stakeholder workshops. Additional insights and clarifications from these sessions were integrated into the analysis. Recommendations for the country reports were co-created with national stakeholders,[3] while recommendations for the global report were further strengthened through guidance from the expert Reference Group.

Table 1: Data collection tools and respondents

Country	Key informant interviews	Survey responses	Focus group discussions	Documents reviewed
Bulgaria	15	51	4	36
Philippines	11	72	2	30
Nigeria	11	40	1	35
South Africa	7	0	1	30

3. The four country reports will be published in 2026.


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Limitations

Study scope: Primary data collection was conducted at six sites across the four focus countries. The global and national literature reviews were not intended to be exhaustive, and the level of detail was constrained by the study's timeframe, scope and the existing evidence. Implementation of multidisciplinary models varied considerably across locations.

The study focused on established multidisciplinary models in each country. In contexts such as Nigeria and South Africa, additional models are also operating; however, these were not included because information on their functioning or interaction with the selected models did not emerge during data collection.

Despite these limitations, the study generated a solid body of evidence. Primary data were triangulated with literature reviews and quantitative surveys, and findings were reviewed by national researchers for accuracy. The strong consistency observed across data sources strengthens confidence in the overall conclusions.

Perspectives of children, adolescents and families: The limited information gathered on children's and caregivers' perspectives was identified as a gap. The study drew on secondary sources, including those related to how service providers gather children's views on service relevance and effectiveness. Forthcoming research, including from Disrupting Harm[4] and the Barnahus Network,[5] will contribute important information on children's and families' perspectives.

Box 1 | Box 2 | Box 3 | Box 4 | Box 5 | Box 6

Multidisciplinary service models reviewed



Bulgaria:
Zona ZaKrila (Child Protection Zone)



Philippines:
Women and Children Protection Unit (WCPU)



Nigeria:
Sexual Assault Referral Center (SARC)



South Africa:
Thuthuzela Care Centre (TCC)

4. See: https://www.unicef.org/innocenti/projects/disrupting-harm.
5. See: https://barnahus.eu/.

3. Multidisciplinary service models: An overview of the models in Bulgaria, the Philippines, South Africa and Nigeria

The four models in Bulgaria, Nigeria, the Philippines and South Africa provide integrated, multidisciplinary care with a foundation in social work and case management, focusing on psychosocial care, family support, and forensic interviews. Annex 1 outlines main characteristics of the models and Annex 2 presents legal mandates and specific services.

In recent years, cognitive behaviour therapy (CBT) has been identified as beneficial for recovery and improved mental health for children exposed to violence.[6] In the Philippines, WCPUs offer Trauma-Informed Psychosocial Processing, a trauma-focused CBT adaptation. Social workers are being trained to deliver Trauma-Informed Psychosocial Processing to address mental health professional shortages.[7]

Three of the models (Philippines's WCPU, Nigeria's SARC, South Africa's TCC) offer services to both adults and children. Bulgaria's Zona ZaKrila is focused solely on providing services to children who are victims or witnesses of violence, as well as their non-abusive parents and caregivers. This model also provides programmes for abusive parents, perpetrators of domestic violence, and children who display harmful behaviours. All four multidisciplinary models emphasise physical, accessible co-location of services as a strategy to reduce the burden on children and families.

3.1 How multidisciplinary teams are structured

Prominent multidisciplinary models bring together professionals from law enforcement, child protective/social services, the judiciary, medical and mental health fields, and victim advocacy.[8] Staff typically include specialized centre managers / coordinators, forensic interviewers, medical professionals (including forensic doctors and paediatricians), psychologists/psychiatrists, police officers, prosecutors, attorneys, and social workers. NGOs, government agencies, and community advocates are also involved, working collaboratively under one roof to provide comprehensive support.

The models in Bulgaria, the Philippines, Nigeria and South Africa have established similar structures for multidisciplinary care, bringing together different disciplines and agencies. However, implementation approach, quality and consistency vary significantly between the different models, as well as across service delivery sites within each country.

6. INSPIRE Strategies, 'INSPIRE Evidence Review Executive Summary,' November 2025. Available at: https://inspire-strategies.org/sites/default/files/2025-11/Nov%202025%20Exec%20Summary_INSPIRE%20Evidence%20Review.pdf.
7. Training programmes, such as the 'Training Leading to a Certificate Course on Trauma-Informed Psychosocial Processing,' are provided to strengthen the capacity of multidisciplinary teams to deliver this service.
8. United Nations Children's Fund, 'Multidisciplinary models of care for Child Victims and Survivors of Sexual Abuse and Exploitation in the Digital Age', pp. 15-20.

Bulgaria: Zona ZaKrila

Core team: social workers, psychologists, forensic interviewers and legal experts.

External partners: child protection agencies, law enforcement, judiciary, schools (in cases of peer violence) and medical doctors (to support medical examinations).

Formal coordination mechanism: mandatory involvement of social services, police, prosecutors and municipal authorities within 24 hours of reported violence.

Location: municipality (local government) provided premises for provision of the services, with the exception of Sofia where the premises is owned by the NGO implementing the service.

Model evolution: Child Advocacy Centre model adapted, to offer specialized services providing integrated support 'under one roof', and piloted in three municipalities and regions; following an external independent evaluation, the pilot was scaled up to include eight more municipalities/regions.

Nigeria: Sexual Assault Referral Centre (SARC)

Core team: doctors, nurses, forensic examiners and counsellors (provided by Ministry of Women Affairs).

Formal coordination mechanism: Steering Committee composed of representatives from three lead ministries: the Ministry of Justice, the Ministry of alth and Social Welfare and the Ministry of Women Affairs and Social Development.

External partners: if children require services beyond those provided by the SARC, cases are referred externally, including the police and Social Welfare Department as appropriate. Referrals are also made to CSOs and private service providers.

SARC staff: centre manager, doctor, nurse, forensic examiner, counsellors, receptionist, finance officer and administrative officer.

Location: majority based in hospitals or medical centres, with some based in other locations.

Model evolution: first SARC was established and is operated by an NGO, while several subsequently established SARCs have been operated by state governments from the outset.

Philippines: Women and Children Protection Unit (WCPU)

Core team: doctors, social workers, mental health professionals an police investigators.

Formal coordination mechanism: mandatory involvement of Local Social Welfare and Development Office and Department of Social Welfare and Development in cases of child abuse, neglect and exploitation.

External partners: Philippine National Police (Women and Children Protection Desk, Women and Children Cybercrime Protection Unit), National Bureau of Investigation, Department of Education, Department of Justice.

Location: majority of WCPU based in hospitals or medical centres, with some based in other locations such as community-based centres.

South Africa: Thuthuzela Care Centre (TCC)

Core team: site coordinator / victim assistant officer (National Prosecuting Authority), doctors and nurses (Department of Health), police investigators and social workers/counsellors (Department of Social Development and NGOs).

Formal coordination mechanism: Sexual Offences and Community Affairs Unit of the National Prosecuting Authority. Pursuant to the Children's Act 38 of 2005, children are mandated to be referred to the relevant designated child protection organizations. The lead CSO (StellCare) of Stellenbosch TCC (visited for the purposes of this study) is an accredited CSO but the Stellenbosch TCC must refer the child offsite to receive services from the CSO, particularly psychosocial care. The majority of TCCs provide direct services to children.

Service model: integrated, survivor-centred one-stop-shop model providing comprehensive services (medical, legal, psychosocial), often in healthcare facilities.

3.2 How the design of multidisciplinary models impacts service delivery

Across countries, multidisciplinary models vary in how fully they are integrated into formal government systems. Bulgaria's Zona ZaKrila and Nigeria's SARC operate largely as NGO-led projects working alongside government services. Others, such as the Philippines' WCPUs, are integrated within government structures from the outset. In Nigeria and Bulgaria, efforts are underway to fully integrate the SARC and Zona ZaKrila models into government service delivery. Stakeholders in all four countries stressed that integration is essential for long-term sustainability.

In theory, NGOs can provide flexibility, innovation, and specialized skills that government systems may lack, but require stable funding and formal partnership agreements to ensure sustainability. When working effectively, government agencies provide oversight, coordination, infrastructure and the potential for long-term financing. The study found that the most effective arrangement is not choosing between government or NGO leadership, but establishing clear, balanced partnerships in which both sectors have defined mandates and government maintains overall ownership.

The WCPU model illustrates this well. Anchored within the public health system and supported by the Department of Health and local government units, WPCUs benefit from an institutional platform and national leadership. The Child Protection Network Foundation contributes specialized technical expertise, training, and quality assurance – an arrangement formalized through the Department of Health Order in 2013. This partnership has supported national scale-up and helped embed child- and gender-sensitive practices within public services.

In Bulgaria, Zona ZaKrila was designed as a demonstration model intended to transition into full government leadership over time. However, this shift has proven difficult in newer sites, where staff report limited recognition from formal system actors. Similar challenges emerged in Nigeria, where government resource and capacity constraints have slowed efforts to assume full leadership of SARCs. In some locations, government partners were either unfamiliar with the service model or viewed it simply as another referral pathway rather than a fundamentally new way of working. Stakeholders emphasized the need for proactive outreach to courts, law enforcement, education, and other government agencies to build visibility, strengthen collaboration, and reinforce the model's role within the broader child protection system.

Funding sources and strategies. All four multidisciplinary models operate through hybrid funding arrangements that combine government allocations with donor and NGO support. This structure enables NGOs to fill critical gaps in service delivery and capacity, but it also introduces financial complexity and dependence on external aid. When donor priorities shift or NGO funding declines, service continuity and quality become vulnerable. Across countries, stakeholders held mixed views on whether current funding levels are sufficient for the multidisciplinary service model to operate effectively.[9]

9. 68 per cent of online survey respondents agreed the model had sufficient resources, 20 per cent disagreed that the model had sufficient resources and 12 per cent neither agreed nor disagreed.

Table 4: Model funding sources

Model	Government funding	External support	Sustainability concerns
Zona ZaKrila	Core statutory	UNICEF, NGO	Challenges relate to coordination and limited state budget support which can affect the quality
WCPU	Department of Health, Local Government Units	Child Protection Network, Consuelo Foundation, UNICEF, UNFPA	Inadequate state budget allocation and dependence on non-dedicated funds
SARC	Transition from NGO to Government funding	RoLAC, CSOs, UNICEF	Service quality decline post takeover
TCC	Public / private partnership (Stellenbosch TCC)	Majority NGO dependent	Unpaid / sub-minimum wages for TCC staff

Human resources. Staffing shortages relative to caseloads affect all four models, resulting in delays, reduced service quality and high burnout (see Section 8). Key aspects include:

- **Staffing shortages and high turnover:** Persistent shortages of specialized professionals (forensic specialists, case managers, nurses) were identified in the Nigeria, South Africa, and Philippines models, with high turnover in contract positions. Staff resign within a few years due to emotional strain and lack of permanent positions.
- **Burnout and inadequate mental health support:** In Bulgaria and the Philippines, limited mental health support for Zona ZaKrila and WCPU frontline workers leads to burnout, emotional fatigue and significant turnover among social workers, psychologists and forensic specialists.

Relationship-based coordination. Effective coordination was frequently attributed to strong interpersonal relationships and leadership of committed individuals. Staff often expedite coordination by bypassing formal channels and leveraging personal connections. However, overreliance on individual relationships renders coordination fragile. Staff turnover and interpersonal conflict disrupt relationship-based mechanisms, which cannot easily be replicated in new locations.

> "Coordination is based on individual relationships rather than institutionalized mechanisms, which could present challenges for replication and long-term sustainability."
>
> Zona ZaKrila staff member, Bulgaria

Integrated service provision for women and children. Existing research on gender-based violence models rarely examine their capacity to address children's unique needs.[10] Three of the models studied – Philippines WCPU, Nigeria SARC, South Africa TCC – serve both women and children, while Bulgaria's Zona ZaKrila is primarily child-focused but also supports parents experiencing domestic violence.

Serving adults and children within the same model can create operational challenges, including competition for limited resources and gaps in specialized, child-focused services. This tension was evident in South Africa's TCC model, where stakeholders expressed differing views on whether children were part of the original design. The initial rationale behind the TCC was to increase conviction rates for sexual offences, while speeding up the time it took to take these cases to court and reducing secondary victimization. Upon opening the first centre in 2000, it soon became apparent that a significant proportion of service users were children. The model quickly put in place measures to ensure the services were child-friendly.[11] Today, clinicians interviewed report that typically approximately 40 per cent of service users are children.

Other models have identified strategies to maintain a specialized approach for children. The Philippines WCPU model demonstrates that with intentional design and dedicated mechanisms, combined models can successfully maintain child-centred services while serving both populations (see **Box 2**). In Bulgaria, Zona ZaKrila supports parents as part of the child's recovery process and, when necessary, provides services to offending caregivers to stop violence and strengthen parenting.[12]

A recurring challenge across gender-based violence models is serving adolescent boys. Many shelters for women with infants and young children are often not designed to accommodate boys. This can lead to family separation and reduced uptake of services by mothers.

Box 1 Box 2 Box 3 Box 4 Box 5 Box 6

Intentional integration with a specialized approach for children in the Philippines

The Philippines WCPU model is intentionally designed to serve both women and children while maintaining specialized, child-centred services. As of November 2025, there are 162 WCPUs and Violence Against Women and Children Desks covering 68 provinces and 10 cities, demonstrating scaled implementation of the combined approach.

Key child-centred approaches include:

1) Children participate in creating their own 'intervention contracts'
2) Standardized communication protocols tailored to children's developmental stages
3) Dedicated child-focused services by trained specialists including psychological care and legal preparation
4) Services individualized according to each child's specific needs, age and vulnerabilities, ensuring a survivor-centred approach.

Despite common risks in combined models, such as the specific needs of child victims being overshadowed by adult cases in units with high caseloads, the Philippines experience suggests that integrated service provision can remain child-focused when supported by clear frameworks, strong partnerships and consistent national leadership.

A remaining challenge noted by stakeholders is managing cases where an adult survivor is simultaneously a suspected perpetrator of child abuse. This can create role conflicts and requires careful handling within the integrated model.

10. United Nations Children's Fund, 'Multidisciplinary models of care for Child Victims and Survivors of Sexual Abuse and Exploitation in the Digital Age: A rapid review of the literature on child-centred services responding to in-person and technology-facilitated abuse', UNICEF, New York, March 2025, p.18.
11. Respondents explained that the TCC Stellenbosch does not provide social work interventions in relation to child protection services per se. If services for children are required, these are referred to another department within the managing CSO. However, the majority of TCCs provide direct services to children.
12. Examples of services provided to non-offending parents and caregivers include counselling and legal aid.

4. What drives effective integration in multidisciplinary models

Integration is essential to multidisciplinary service models but requires more than co-location or formal agreements. Evidence from all four study countries shows that effective integration depends on active coordination, clear roles and shared commitment across agencies. Common challenges include unclear mandates, weak communication channels and interagency tensions.

4.1 Key factors that enable integration

1) **Frequent coordination, not periodic meetings.** Routine mechanisms, such as daily meetings,[13] joint interviews, and case reviews, are more effective than monthly meetings in maintaining alignment and responding quickly to emerging issues.
2) **Institutionalized coordination, not reliance on individual champions.** While strong personal relationships often catalyse collaboration, they are insufficient for long-term sustainability. Integration must be embedded through protocols, training, supervision and accountability systems.
3) **Flexible use of co-location with strong links for external services.** Co-location improves communication and reduces delays, but many specialized services cannot be on-site. Strong referral pathways, supported by formal agreements, joint reviews and feedback loops, are essential to maintain continuity of care.
4) **Dedicated resourcing for coordination functions.** Coordination takes time and cannot be an add-on to existing workloads. Models need explicit budget lines for coordination roles, interagency meetings and joint activities.
5) **Facilitating interagency exchange.** Differences in professional cultures and procedures mean integration cannot be assumed. Structured opportunities for agencies to openly discuss challenges, such as the multi stakeholder exchanges facilitated in Nigeria[14] and Bulgaria,[15] help resolve conflicts and build shared understanding.

13. For example, in the **Philippines**, topics for daily meetings include case review and information coordination from the previous day, including any issues requiring further discussion. Participants include all members of the multidisciplinary team (doctor, psychologist, social worker) to ensure streamlined case management.
14. For example, the Rule of Law and Anti-Corruption programme in **Nigeria** organises annual conferences for the SARC Network. The focus of these meetings is to facilitate idea exchange, share lessons learned, and promote dialogue among SARCs, government institutions and other stakeholders. Participants are invited to raise and discuss the challenges they face and explore ways to improve outcomes for survivors. National partners include the Federal Ministry of Justice, the Federal Ministry of Women Affairs, the National Agency for Prohibition of Trafficking in Persons, International IDEA, and CSOs.
15. For example, the Research Team attended a meeting involving government and municipal officials and multidisciplinary service providers in Shumen, **Bulgaria** in February 2025 hosted by the NGO SAPI responsible for the Zona ZaKrila model as part of the Complex for Social Services for Children and Families in Shumen Municipality. This was an opportunity for representatives from different sectors to come together to openly discuss coordination across their agencies, including both what was working well, as well as the challenges they are facing.

Managing external referrals. While multidisciplinary models strive to provide integrated on-site services to reduce the need for external referrals, not all services can be co-located. For example, external referrals are often required to specialized service providers such as:

- Long-term mental health care for children (ongoing therapy over months / years).
- Specialized services (psychiatric assessment, developmental evaluation, substance abuse treatment)
- Community-based outreach and support (home visits, family therapy)
- Education support (special education, tutoring, school reintegration)
- Economic support (livelihood programmes, financial assistance)
- Shelter (safe accommodation)

Breakdowns occur when families face access barriers (such as transportation costs and wait times), receiving agencies lack information leading to repeated assessments, or feedback loops are weak.



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Example: In Nigeria, SARCs frequently function as referral hubs, linking survivors to external support services such as legal aid, safe shelters and specialized medical care including psychiatric services and antiretroviral therapy. These partnerships are guided by formal referral directories, although their effectiveness depends on timely and coordinated responses from external service providers.

4.2 Variations in integration across service types

Across all models, the strongest integration occurs in emergency medical examination, forensic evidence collection, and initial psychosocial support.[16] Moderate integration is seen with law enforcement and prosecution, where police investigators participate in child-friendly interviews to take victim and witness statements. For example, in the Philippines, prosecutors work closely with WCPU staff to support case-building, coordination of investigation details and to ensure the child victim's well-being and effective testimony in court. In Bulgaria, police are required to participate in the coordination mechanism within 24 hours.

In South Africa, police investigators are either based at or closely linked to TCCs. In Nigeria, police take statements at SARCs if they are co-located in the centres. In most other cases, statements are taken at the police stations before the survivors are referred to the SARCs. In cases where the survivors visit the SARC first, they are referred to the police station for interview and statement. However, coordination beyond this initial stage is reportedly weak. Poorly integrated or missing areas across all four models include long-term healthcare beyond immediate medical examination and coordination with schools and the education sector.[17]

Box 1 | Box 2 | **Box 3** | Box 4 | Box 5 | Box 6

Slow judicial processes – a common challenge

- **Zona ZaKrila:** Respondents noted legal proceedings are "often slow and complex," particularly in cases of technology-facilitated abuse
- **WCPU:** Respondents noted the constant rotation of police personnel breaks continuity; prosecutors and courts handle proceedings, but timelines are often lengthy
- **SARC:** Respondents highlighted the slow judicial response
- **TCC:** Respondents explained that whereas cases previously took 3-5 years, the establishment of the TCC model reportedly reduced this timeframe to under 6 months in some sites

16. For example, this includes the **WCPU** in the Philippines, which conduct joint interviews involving a police investigator, doctor, and social worker to minimise repeated retellings and enable real-time follow-up; the **Zona ZaKrila Blue Rooms** in Bulgaria, which provide child-friendly environments for forensic interviewing with multidisciplinary team coordination; the **SARC** in Nigeria, which co-locate medical examination and crisis counselling; and the **TCC** in South Africa where medical examination and forensic extraction of evidence form the core integrated services provided by the model.

17. For example, in Bulgaria's **Zona ZaKrila**, provision of healthcare and medical-forensic services is less consistent due to a shortage of forensic medical experts, especially outside major cities. This results in lengthy delays and limited access to child-friendly environments for medical examinations, and the broader healthcare sector remains not yet well integrated due to limited understanding of their critical role. In the Philippines **WCPU**, acute medical care is strong, but access to mental health services is often delayed due to personnel shortages and limited in-house mental health professionals, leading to a reliance on external referrals and wait times that can reach up to one year. In Nigeria's **SARC**, medical services are provided but integration with the broader health system for follow-up care is unclear. In South Africa's **TCC**, health services are not available after hours, and victims are referred to casualty departments where they must wait for a forensic nurse or doctor.

5. Adaptability to the digital age

Multidisciplinary models are increasingly encountering cases of technology-facilitated child sexual abuse and exploitation, but current systems are not designed or resourced to respond effectively.[18] Stakeholders across all four countries reported a rise in cases of technology-facilitated sexual exploitation and abuse, but statistics on the number of cases handled and types of services offered were not available. Capacity to recognise and respond to technology-facilitated abuse remains highly variable and generally limited.

Gaps in identification and intake. Questions about technology-facilitated abuse are not part of standard intake interviews or routine assessments, meaning cases involving online abuse often go undetected. Most cases come to light only when:

- children or caregivers disclose spontaneously (this is rare due to shame, lack of awareness of this form of harm, or fear)
- physical abuse brings a child to services
- police, often acting on foreign referrals,[19] identify victims.

As a result, technology-facilitated abuse remains largely invisible within multidisciplinary models.

Limitations in staff skills and system preparedness. Across all multidisciplinary service models, staff emphasized that while they are increasingly encountering technology-facilitated abuse, they do not feel adequately equipped to respond and requested further training and support. Training initiatives have been sporadic and limited in scope. Not all professionals, particularly those in government agencies, have had the opportunity to participate in capacity-building initiatives on this topic. The rapid evolution of online exploitation compounds this challenge.

Box 1 | Box 2 | Box 3 | **Box 4** | Box 5 | Box 6

Tracking cases of technology-facilitated sexual abuse in case management systems

The Philippines' Women and Children Protection Management Information System (WCP MIS) has been recording cases of technology-facilitated child sexual exploitation brought to WCPUs since 2021.

The **Bulgaria Zona ZaKrila** model collects data on number of cases, demographics, types of abuse reported, and services provided, with respondents highlighting that data is used to identify trends (for example, rising cases of technology-facilitated abuse). This suggests some classification of online abuse cases exists in data collection, though whether this is systematic and standardized across all sites is unclear.

In **Nigeria and South Africa**, no information was available on whether case management systems distinguish technology-facilitated cases or capture digital dimensions of abuse.

18. United Nations Children's Fund, 'Multidisciplinary models of care for Child Victims and Survivors of Sexual Abuse and Exploitation in the Digital Age', pp. 24-28.
19. Referral of cases of technology-facilitated abuse by foreign authorities was noted by respondents in the Philippines and Bulgaria.

Service gaps for affected children. None of the four models offer specialized services or tailored interventions for children who experience technology-facilitated harm. Cases are managed using the same approaches as other child protection concerns, which may not address the distinct needs of children that have experienced technology-facilitated abuse.[20] For example, there may be limitations in utilising trauma-informed care approaches with children affected by technology-facilitated harm, as many do not perceive themselves as victims or as having directly experienced trauma.[21]

Fragmented referral pathways. Cases of technology-facilitated abuse are typically handled directly by police or national hotlines. This pattern, also found in other contexts such as Sweden, Singapore and Thailand, means that cases are investigated and managed primarily by law enforcement without the involvement of social services, psychologists, or other child protection practitioners.[22] As a result, children may not receive the psychosocial support, therapeutic care or follow-up care they require, although some ad hoc referral to support services may take place.[23] Another gap across the four study countries is the absence of formal linkages between multidisciplinary models and national cybercrime authorities, including units with capacity to take down abusive content.

While police are often the first point of contact for cases of technology-facilitated sexual abuse and exploitation, officers are not always aware of the broader range of services available or how to refer children's cases to multidisciplinary teams. Stakeholders in the Philippines expressed concern that many cases initiated by foreign law enforcement are never referred to WCPUs for victim services. Similarly, referral procedures between national hotlines for online abuse and multidisciplinary service models are not well defined.

20. See for example: Child Frontiers, Psychosocial Support and Children's Rights Resource Center, and UNICEF Philippines, 'Study on Intervention Strategies for the Rehabilitation and Reintegration of Child Victims/Survivors, UNICEF Philippines', November 2023. Available at: https://www.unicef.org/philippines/reports/online-sexual-abuse-and-exploitation-philippines.
21. Ibid. pp. 53-55.
22. A 2025 study by World Childhood Foundation found that 'children exposed to online child sexual abuse are rarely interviewed at Barnahus, which reduces the possibility of coordinated support between the police, social services, child and adolescent psychiatry, and other services': World Childhood Foundation, 'Gaps in the System: Practitioners' experiences supporting children subjected to online sexual abuse,' 2025. Available at: https://childhood.org/wp-content/uploads/2025/06/childhood-report-gaps-in-the-system-1.pdf.
23. In **Bulgaria**, for example, formal coordination between Zona ZaKrila and the Safer Internet Centre has yet to be established. However, the Safer Internet Centre refers cases to Zona ZaKrila when relevant, ensuring that children receive appropriate support. Zona ZaKrila does not have formal, established points of contact with hotlines or cybercrime units. In situations where children need assistance with issues such as removing abusive content, these cases are typically managed through referrals and collaboration on an as-needed basis rather than through a structured protocol. In **South Africa**, TCC deal with the Family Violence, Child Protection, and Sexual Investigations unit but not the Serial and Electronic Crime Investigation unit that has been established for online crimes. Other study CSO informants do reportedly coordinate with the Serial and Electronic Crime Investigation unit.

Adaptations for the digital age. Current models were designed for in-person, contact-based physical or sexual abuse, often requiring medical intervention. Most multidisciplinary models operate without:

- routine screening for technology-facilitated abuse during intake
- specialized therapeutic approaches for different types of technology-facilitated sexual abuse and exploitation
- specialized training for multidisciplinary teams[24]
- updated referral pathways for addressing technology-facilitated sexual abuse and exploitation
- systematic recording of cases involving digital dimensions.

Without proactive systems in place to identify and adapt services to appropriately respond to emerging forms of harm, including but not limited to technology-facilitated sexual abuse and exploitation, multidisciplinary service models risk failing to provide the necessary response and support for children.

> "Actually, cases of technology-facilitated harm are increasing. Our problem is that they're just not being reported. We see, we hear, we know that there are many cases, and we also know which places have widespread challenges."
>
> WCPU staff member, the Philippines

24. This includes understanding and addressing the unique psychological and emotional impacts this form of harm can have on children in a trauma-sensitive way and utilising multidisciplinary approaches that ensure child safety and emotional stabilization. See for example: Birgersson, A, and Jonsson, LS, *Crisis intervention guidelines and protocol: Supporting child victims of online sexual abuse*, 2025, developed as part of the EU PROMISE Elpis project. Available at: https://barnahus.eu/2025/06/27/crisis-intervention-guidelines-and-protocol-supporting-child-victims-of-online-sexual-abuse/.

6. Child-centred approach and community linkages

A child-centred approach requires services to support children's age, gender, abilities, and individual vulnerabilities. While all four multidisciplinary models aim to individualise care, the depth and consistency of these adaptations vary. The Philippines' WCPUs demonstrate the most explicit age-differentiated practices (see **Box 2** above), while Bulgaria's Zona ZaKrila incorporates specialized forensic environments (i.e. using 'Blue Rooms' equipped with two-way mirrors, closed-circuit television, and anatomically correct dolls). South Africa's TCC and Nigeria's SARCs offer child-friendly elements. However, some stakeholders interviewed in South Africa noted significant challenges in counselling children and stressed that additional training is required. In Nigeria, some stakeholders expressed a desire for greater consistency in child-centred approaches across SARC sites.

Gender considerations are acknowledged across models yet remain inconsistently operationalized. Stakeholders in Bulgaria and the Philippines noted girls' heightened risk and boys' reluctance to disclose abuse due to stigma, which require more intentional approaches. The views of children and adolescents are sometimes captured during interviews or counselling, but systematic collection of feedback on service quality and use of this information to improve care remains limited.

25. Stakeholders in Bulgaria explained that the Zona ZaKrila Plus model extends the original model scope from child victims or witnesses to all children participating in legal or administrative procedures, including those in conflict with the law and exhibiting harmful behaviours. This expanded model strives to support all children, including those who have committed crimes that are violent, hurtful and sexual in nature. Zona ZaKrila Plus aims to institutionalise this broader approach using psychological and social interventions rather than punitive measures.

26. For instance, Philippines' WCPU demonstrates strong community integration through Barangay Councils for Protection of Children, VAWC Desk Officers, and TeleCPU network (138 satellite centres in barangays/municipal offices) which deliver integrated child protection services using technology and are highly valued by both beneficiaries and local stakeholders. Bulgaria's Zona ZaKrila multidisciplinary mobile teams provide on-site crisis response in select areas (Shumen), but structured links to community are considered weak overall. Information on structured community linkages was limited in relation to Nigeria's SARCs and in some cases, cultural stigma and interference from community leaders can obstruct access to care.

Support for marginalized groups, including children with disabilities, LGBTQI+ children, migrant and refugee populations, and ethnic minorities, remains underdeveloped. While some models emphasise non-judgmental care and inclusive outreach (for instance, Zona ZaKrila's outreach to Roma communities), specialized protocols and skills are limited across all countries.

Capacity to support children displaying harmful behaviours is minimal across models. Bulgaria's Zona ZaKrila Plus model is working towards building capacity to support all children in need of assistance and care, including those exhibiting harmful behaviour.[25]

Community linkages and outreach vary across the models.[26] In Nigeria in particular, outreach was highlighted as essential to address stigma, cultural silence, and family-level interference that obstruct reporting and access to justice. Expanding community partnerships is key to improving accessibility, ensuring cultural relevance, and building trust in services.

Box 1 Box 2 Box 3 Box 4 Box 5 Box 6

Examples of identified barriers to child participation

- Resource constraints limiting staff time and capacity for consultation
- Fear of retraumatization through follow-up contact
- 'Expert-driven' service design culture that positions professionals as knowers and children as recipients
- Lack of child-friendly consultation methods and staff training in participatory approaches
- When children are consulted, they focus on personal needs not systemic feedback
- High workloads making additional evaluation activities feel burdensome

7. Evaluating effectiveness and ongoing systems of monitoring

Globally, there remains a need for more systematic data collection, analysis and use to support evidence-based policymaking and service improvement.[27] Across the multidisciplinary models reviewed in Bulgaria, Nigeria, the Philippines, and South Africa, basic monitoring and evaluation systems exist, but these vary widely in sophistication and institutionalization.

- **Philippines' WCPU:** The Department of Health signed a Memorandum of Agreement with the Child Protection Network, formally recognising the Women and Children Protection Management Information System as the official national data source capturing levels and trends of violence against women and violence against children used for policy development and planning. This institutionalization ensures sustainability beyond individual donor projects and provides legitimate authority for data-driven policymaking. Some units reportedly use online satisfaction surveys via Google Forms after TeleWCPU consultations, making feedback collection convenient and less burdensome while enabling remote service users to provide input.
- **Bulgaria's Zona ZaKrila model** has two levels of monitoring and evaluation. NGOs managing the centres (SAPI and Animus) submit regular reports containing quantitative and qualitative data to funding partners. This includes local government municipalities who fund the services after the initial pilot and UNICEF, which provides external support for quality assurance and scale-up. The model collects both quantitative data (number of cases, demographics, types of abuse, services provided) and qualitative case summaries based on children's narratives, providing richer understanding of their priorities and views on the outcomes provided. However, there is scope to strengthen strategies for collecting follow-up information from children and families on the quality and impact of interventions and systematic opportunities for clients share their views and recommendation on the approach and services.

- **Nigeria's SARCs** collect basic service data that is shared with the Rule of Law and Anti-Corruption Programme (RoLAC) on a regular basis, and some centres maintain checklists, peer reviews and hold daily staff check-ins. RoLAC consultants conduct observation visits for quality assurance and mentoring. Annual RoLAC conferences provide knowledge-sharing platforms and peer learning opportunities are organized for staff from struggling SARCs to visit more successful ones. Evaluations are limited to SARCs that are required to conduct these for external donor reporting, such as the Mirabel Centre.
- **South Africa's TCCs** collect quantitative survivor satisfaction data, including a survey comparing TCC versus non-TCC survivor experiences across multiple dimensions (police treatment, waiting times, dignity, satisfaction). This comparison group design allows assessment of the model's added value beyond standard services. The TCC evaluation framework includes monthly Programme Implementation Committee meetings at each site, monthly Department of Health monitoring visits to assess service quality, annual Department of Health evaluations and facility checklists. The TCC system also tracks reported cases, court cases, finalized cases, convictions and acquittal rates. However, this is not always consistently implemented across all TCCs.[28]

Data collection and learning. All four models collect essential operational data such as number of cases handled, services provided, immediate satisfaction, and in South Africa, case turnaround times and conviction rates. However, data use lags behind data collection. Information generated is not consistently analysed or applied to improve service quality. The absence of comprehensive evaluation frameworks makes it difficult to assess the quality of services or children's long-term outcomes, including reductions in trauma symptoms or revictimization.

Service providers noted the tension between evaluation demands and practical realities. High caseloads limit staff capacity to undertake additional assessment tasks, and there are concerns about unintentionally retraumatizing children and families through repeated follow-up for evaluation purposes.

> "SARCs rely heavily on the trust of the survivors and the public, if they do not have that trust, they will not be successful."
>
> SARC staff member, Nigeria

27. United Nations Children's Fund, 'Multidisciplinary models of care for Child Victims and Survivors of Sexual Abuse and Exploitation in the Digital Age', p.37. For example, of the 28 countries studied with Barnahus or Barnahus-type services in place, only six (Denmark, Finland, Norway, Poland, Spain and Sweden) reported evaluations of services: Greijer, S and Wenke, D, 'Barnahus: a European journey - Findings of a mapping study on multidisciplinary and interagency child-friendly justice models responding to violence against children', Council of Europe, 2023, pp. 85–88.
28. Significant variations were identified in the Foundation for Professional Development's Compliance Audit and Gap Analysis: Foundation for Professional Development. Thuthuzela Care Centres Compliance Audit and Gap Analysis. Pretoria, Foundation for Professional Development, 2016. Available at: https://www.foundation.co.za/document/publications/reports/TCC%20annual%20report-inside%20pages.pdf.



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Child and adolescent participation in monitoring and evaluation

Bulgaria: The Zona ZaKrila model collects informal feedback during therapy sessions and case discussions with parents and children, but opportunities for families or children to offer input on the model itself are limited. Zona ZaKrila staff explained that children also actively participate in planning their care and express their preferences regarding the services and interventions provided.

Nigeria: The SARC model relies predominantly on parent voices rather than children's, with feedback collected through post-service forms and occasional telephone interviews that primarily capture caregivers' experiences and interactions with beneficiaries. Staff explained that direct satisfaction surveys and opportunities for children to participate in evaluation are not consistently implemented due to funding constraints.

Philippines: The WCPU model integrates child participation through the Valenzuela City's Child Protection Center's Intervention Contract process, where children actively participate in planning their care. Some WCPUs also collect feedback through online satisfaction surveys, videotaped group discussions, and informal staff conversations, though younger age groups are less represented.

South Africa: The TCC model does not appear to have a standardized system-wide mechanism for formally consulting children and families on service delivery or improvement across TCCs. Feedback mechanisms largely focus on immediate service experiences.

8. Service provider support and capacity building

Greater supervision and support for professionals working with children affected by violence is needed.[29] Services are often delivered within physically and psychologically difficult environments.[30] Stakeholders identified individual and group reflective supervision, counselling, complementary training and professional interest groups as effective support strategies. Despite significant resource constraints, senior management of the services visited have developed creative solutions for supporting service providers. In all four countries, stakeholders emphasized the importance of service provider support and the need for continuing efforts to ensure consistent and responsive care for frontline professionals and caregivers given the high stress and challenging nature of this work.

> "[There is the] issue of secondary trauma. You cannot see 10,000 survivors and not be traumatized... quite a number of staff resigned after two years, they could not cope with it, they were too traumatized. So that became a major issue."
>
> SARC staff member, Nigeria

During interviews conducted, NGO and government service providers, including police, prosecutors and judges described the high level of personal stress they experience in their roles. This is often compounded by their efforts to achieve positive outcomes for children and families. Respondents were clearly deeply committed to helping the children they serve but explained that in some cases the best course of action is not possible due to lack of sufficient evidence, court decisions or unwillingness of children and families to pursue cases. This is especially true for cases of technology-facilitated abuse. While children and families may report cases to remove explicit material online, they often prefer not to pursue legal action due to fear of stigma, further stress and trauma from the legal process, which can be lengthy, difficult and, in some cases costly.



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29. United Nations Children's Fund, 'Multidisciplinary models of care for Child Victims and Survivors of Sexual Abuse and Exploitation in the Digital Age', p. 42.
30. Greijer and Wenke, 'Barnahus: A European journey', p. 26.

Some promising models are emerging:

- **Bulgaria (Zona ZaKrila):** NGOs SAPI and Animus providing structured staff wellbeing programmes, including psychological counselling and support, professional supervision, peer support groups, stress management sessions and debriefing following severe cases.
- **Philippines (WCPUs):** 'Care for the Caregivers' activities are held twice yearly and supplemented by free online Trauma-Informed Care training. Hospital-based WCPU staff have access to psychologist and psychiatrist services.
- **Nigeria (SARCs):** Staff receive mental health first aid training, psychological support and case debriefing, with efforts underway to strengthen consistency.

Despite these initiatives, support often becomes available only after burnout emerges, rather than through regular and structured wellbeing assessments.

Example – Philippines' Vicente Sotto Memorial Medical Center WCPU informal staff support mechanisms

- Social workers share complicated cases before leaving for the day
- Monthly peer reviews that serve as debriefing sessions
- Daily patient load limits for staff: (doctors: 5-6 patients; psychologists: 2-3 patients)
- Team lunches without work discussion
- Monthly birthday celebrations to foster team dynamics



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The pattern of underfunding and undervaluing frontline psychosocial workers creates a structural weakness across all multidisciplinary models:

- **Bulgaria:** State employees working directly with the Zona ZaKrila model have no Institutionalized psychological support despite high stress
- **Nigeria:** High staff turnover due to trauma, overwhelming caseloads
- **Philippines:** Staff feel guilty taking mental health breaks, 'sabak agad' (trial by fire) deployment
- **South Africa:** Counsellors paid below minimum wage, lowest status, considered 'low-skilled'

Capacity building approaches

All four models recognise capacity building as a core requirement, yet efforts remain uneven and heavily dependent on project funding.

- **Philippines:** The Child Protection Network provides a standardized curriculum, including free online basic training covering the 4R's (recognition, recording, reporting, referring), Multidisciplinary Team Training and Specialty Training with two-week practicum, supported by annual conferences. However, the 'trial by fire' practice of immediate staff deployment remains a challenge.
- **Bulgaria:** Zona ZaKrila has developed induction and specialized training programmes for staff and key stakeholders. NGO partners have also developed training modules addressing online grooming, sexual extortion and cyberbullying. Other training topics include trauma-informed care, forensic interviewing, psychological first aid, case management, and risk assessment. However, the project-based nature and lack of standardization of these training programmes reportedly remains a challenge.
- **Nigeria:** The annual RoLAC SARC Network Conferences provide a platform for peer learning and practice exchange. Recent sessions included technology-facilitated gender-based violence. A national cadre of medical and counselling trainers, first trained by St. Mary's SARC in Manchester, United Kingdom, is now responsible for ongoing staff development.

9. The way forward

When properly designed, adequately resourced and systematically rolled out, multidisciplinary models prove effective in delivering coordinated, survivor-centred responses that address the complex needs of children. However, the gap between aspiration and reality remains substantial particularly in resource-constrained environments. The fundamental challenge is one of scale. If multidisciplinary models are to be integrated as core components of national child protection systems, they must be accessible on an equitable basis to entire populations rather than limited to capital cities or pilot locations. This demands an affordable, sustainable approach to scaling across all subnational administrative units, a transition that has proven elusive in most contexts.

The Philippine experience with Women and Children Protection Units offers valuable lessons on transitioning to national coverage, demonstrating both possibilities and persistent barriers. Similarly, Bulgaria's Zona ZaKrila initiative shows promise through UNICEF and NGO collaboration with municipal governments to embed the multidisciplinary approach into local child protection service delivery, though implementation remains limited to select locations. Efforts are also underway to transition multidisciplinary models in Nigeria and South Africa to government leadership and scale up service provision.

To address persistent gaps and improve outcomes, fragmented coordination mechanisms, inadequate resourcing, workforce capacity gaps, and underdeveloped monitoring systems must be overcome. Services also need to identify and evolve to address child sexual exploitation and abuse in the digital age. Ultimately, closing persistent gaps will depend on sustained commitment from governments, donors, and partners to scale what works for children to support children who have experienced sexual abuse and exploitation. Continued cross-country learning can further support progress by enabling stakeholders to share practical solutions, adapt innovations to their own contexts, and jointly address evolving forms of abuse enabled by digital technologies.

Annex 1: Key characteristics of multidisciplinary models in Bulgaria, Nigeria, Philippines and South Africa

Country	Model Name	Year Established	# of centres nationwide	Lead Agency / Organization	Key Stakeholders / Partners
Bulgaria	Zona ZaKrila (Child Protection Zone)	2015	11	The pilot model was developed with UNICEF support by NGOs: SAPI (Social Activities and Practices Institute) and Animus Association Foundation – NGO and implemented in 3 Municipalities and regions. The model has been scaled up in 8 new regions as part of existing social services managed and run by local municipality governments on their own or in partnership with NGO service providers.	• Agency for Quality of Social Services Municipal governments • Agency for Social Assistance • Child Protection Departments • Ministry of Labour and Social Policy • Ministry of Interior • Ministry of Justice • Police, Prosecutors, Courts • Regional Governors • State Agency for Child Protection
Nigeria	SARC (Sexual Assault Referral Centre)	2013 (First SARC: Mirabel Centre)	50	The NGO, Partnership for Justice Nigeria, established the first SARC. Many subsequent SARCs have been established and operated by state governments from the outset.	• Justice for All Programme • Lagos State University Teaching Hospital • Law Enforcement agencies • Ministry of Women's Affairs • Ministry of Health • Ministry of Justice • Ministry of Education • UK DFID (initial funding 2010-2017)
Philippines	WCPU (Women and Children Protection Units)	1996-1997 (WCPU piloted in 1996 and first CPU established in 1997)	162	• Department of Health • Child Protection Network Foundation	• Consuelo Foundation • Department of Education • Department of Social Welfare and Development • International Justice Mission • Local Government Units • National Bureau of Investigation • Philippine Commission on Women • Philippine National Police: Women and Children Protection Desk; Women and Children Protection Center; Women and Protection Cybercrime Protection Unit • UNICEF • University of the Philippines Manila
South Africa	TCC (Thuthuzela Care Centres)	2000 (First TCC established June 2000 in Cape Town)	55	• National Prosecuting Authority • Sexual Offences and Community Affairs Unit	• Departments of Education, Treasury, Correctional Services, Local Government, Home Affairs • Department of Health • Department of Justice • Department of Social Development • NGOs (Mosaic, Centre for the Study of Violence and Reconciliation, Masimanyane, National Institute for Crime Prevention and the Reintegration of Offenders, Childline) • Shelters • South African Police Service

Annex 2: Legal mandate and services provided by multidisciplinary models

Model	Legal Mandate and Services Provided
 **Bulgaria: Zona ZaKrila**	**Legal mandate:** Social Services Act; Action Plan for the Implementation of the National Program for the Prevention of Violence and Child Abuse (2023-2024) Services provided: • Forensic and Child-Friendly Interviews: "Blue Rooms" for video-recorded interviews by trained professionals • Crisis Intervention and Emergency Protection: Immediate risk assessment within 24 hours, emergency removal from unsafe environments • Psychological Support and Therapy: Trauma-informed counselling, ongoing rehabilitation, family mediation • Medical and Forensic Examinations: Access to forensic doctors for documenting injuries, coordinated medical care • Additional services: Legal support, case coordination, mobile services for hard-to-reach communities, prevention programmes and specialized programmes for perpetrators.
 **Nigeria: SARC**	**Legal mandate:** Violence Against Persons Prohibition Act 2015; National Strategic Framework for the Prevention and Response to SGBV (2023-2026); Child Rights Act (2003); National Policy on Child Protection Services provided: • Medical examination and treatment (PEP, STI prevention) • Psychosocial counselling • Legal support and referrals • Emergency contraception • Documentation for legal processes • Family empowerment programmes, scholarships, and shelter referrals • Community awareness campaigns
 **Philippines: WCPU**	**Legal mandate:** Department of Health Administrative Order No. 2013-0011 (Revised Policy) Services provided: • Intake and Triage: Pre-registration, vital signs check, assessment for immediate medical emergencies by a nurse • Medical Services: Medico-legal exams, treatment, mental health screening, referrals to specialists • Joint Interview and Assessment: Police, doctor, and social worker present for child's narration to prevent retraumatization • Psychosocial Services: Psychological First Aid, screening, therapy, specialized programmes like Personal Safety Lessons • Social Work and Case Management: Safety assessments, shelter placement, intervention contracts, local social welfare and development office coordination (mandated to be the primary case manager) • Legal and Justice System Support: Paralegal counselling, court preparation, coordination with prosecutors and family courts • TeleWCPU Services: Online counselling and medical follow-ups for remote families
 **South Africa: TCC**	**Legal mandate:** National Prosecuting Authority's Sexual Offences and Community Affairs Unit. TCC operations are guided the TCC Blueprint policy document and the National Management Guidelines for Sexual Assault, 2003. Services provided: • Counselling, medical care, police, and prosecutorial services under one roof • National Prosecuting Authority: Coordination, legal support, case management • Healthcare: Medical examination, evidence preservation • Social Services: Support, care, counselling, debriefing • Law Enforcement: Case opening, victim transport to TCC • Civil Society: Transport, emotional support, awareness


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