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Multidisciplinary models of care in Nigeria

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



Safe Online

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Research team:

- Vimala Crispin – Deputy Director, Child Frontiers;
- Elaissa Mendoza – Senior Associate, Child Frontiers;
- Dr Bisayo Odetoyinbo – Influence Consults;
- Dr Jaiyesimi Ebunoluwa – Influence Consults.

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Executive summary

When children have suffered abuse, they have a right to access services that support healing, protection and justice. This requires coordinated support from practitioners from multiple specialized disciplines, including police investigators, prosecutors, social workers, medical professionals and psychologists. 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.[1] However, evidence remains limited on how such models operate across diverse socioeconomic contexts and on their capacity to respond effectively to technology-facilitated harm.[2]

This report is one of four country reports produced as part of this study, and it presents findings from a rapid global literature review, a country-level document review and fieldwork conducted in Nigeria focusing on the Sexual Assault Referral Centre (SARC) model, which is the primary model used for implementing multidisciplinary services for child victims and survivors of sexual violence in Nigeria.

The Sexual Assault Referral Centre model

SARCs offer a one-stop service designed to provide integrated, coordinated and survivor-centred care to individuals, including children, affected by sexual assault. Located primarily within hospitals and medical facilities, to leverage existing health-care infrastructure, SARCs bring together a core team of doctors, nurses, forensic examiners and counsellors, operating under a formal coordination mechanism involving the ministries of justice, health and women's affairs.

For cases where services are required beyond a SARC's core offerings, referrals are made to law enforcement agencies, social welfare departments, civil society organizations (CSOs) and other relevant partners, as appropriate, with the aim of ensuring a continuum of care across the medical, psychosocial, forensic and legal domains.

The rationale for the SARC model was based on the recognition that existing sexual assault response services in Nigeria were fragmented, inadequate and frequently denied survivors access to justice and high-quality support, particularly owing to the difficulty of obtaining credible medical evidence, which contributed to persistently low conviction rates. The first SARC in Nigeria, the Mirabel Centre, was established in 2013 at the Lagos State University Teaching Hospital by the non-governmental organization (NGO) Partnership for Justice Nigeria, with funding from the UK Government's then Department for International Development.[3] Subsequent momentum for the model was significantly bolstered by the enactment of the Violence Against Persons Prohibition Act in 2015, which strengthened the legal framework for prosecuting perpetrators of sexual and gender-based violence and catalysed the establishment of SARCs across additional states. Growth of the SARC model has been further supported by the Rule of Law and Anti-Corruption Programme (now the International Institute for Democracy and Electoral Assistance) funded by the European Union. This programme has provided financial and technical assistance to state governments for SARC establishment and expansion. As of March 2026, 52 SARCs were operational in Nigeria across 25 states inclusive of the Federal Capital Territory.

1 United Nations Children's Fund, *Multidisciplinary Models of Care: Strengthening services for child victims and survivors of sexual abuse and exploitation in the digital age*, UNICEF, New York, December 2025.

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.

3 Dissolved in 2020 and merged with the Foreign and Commonwealth Office to form the Foreign, Commonwealth and Development Office.

Opportunities and learning

Nigeria's SARC model has created an increasingly visible and trusted entry point for survivors of sexual violence, including children, enabling them to access coordinated medical, psychosocial and legal support. The study findings reveal that survivors and their families reported that SARCs provide a safe, confidential environment that reduces the burden on survivors and enables timely access to essential services. For example, families often note that receiving medical and psychosocial assistance in one location often mitigates trauma and reduces the need to navigate multiple institutions independently.

The study found that the multidisciplinary design of the SARC model is valued by stakeholders across states, and that the expansion of the SARC Network, supported by government, CSOs, and development partners, signals a strong national commitment to improving care for survivors. As with other multidisciplinary models investigated in other countries as part of this study, the SARC model demonstrates the importance of embedding multidisciplinary service models into existing systems while continually adapting them to operational and contextual realities. The findings from Nigeria identify several opportunities for strengthening and scaling up the model to ensure that all children can access high-quality support nationwide.

Nigeria's experience also demonstrates that multidisciplinary coordination depends not only on bringing services together but also on cultivating strong cross-agency relationships, clear leadership and structured processes. The Mirabel Centre, based in Lagos state, offers a strong example of what an effective coordinated SARC response can look like, with the Domestic and Sexual Violence Agency facilitating collaboration among government ministries, NGOs, law enforcement agencies and specialized courts to deliver a comprehensive, survivor-centred pathway.

As found with the other multidisciplinary models investigated in other countries as part of this study, however, implementation varies across states. Some centres rely heavily on informal relationships rather than systematic referral protocols, and linkages with the justice and education sectors remain inconsistent. Rather than indicating weaknesses in the model, these variations reflect limitations of the broader systemic context within which SARCs operate. This also highlights significant opportunities for strengthening integration through sharing protocols, developing clearer mandates and improving coordination mechanisms.

SARCs in Nigeria are increasingly encountering cases involving technology-facilitated sexual abuse and exploitation. Respondents identified sexual extortion, cyberbullying with sexual content, the circulation of child sexual abuse material and online grooming as emerging concerns affecting children. While systematic approaches to addressing online abuse are still developing, the SARC model's foundation in psychosocial and medical care provides a strong platform for incorporating assessment of technology-facilitated abuse, specialized therapeutic approaches and updated referral pathways. First steps, such as sessions at SARC Network conferences on technology-facilitated abuse, demonstrate motivation to adapt services in line with children's changing realities.

Nigeria also faces structural and cultural barriers that can prevent children and families from accessing services. Respondents highlighted stigma, the culture of silence and financial constraints as common obstacles, particularly in cases where perpetrators are family members. These challenges underscore the importance of deepening community engagement and targeted outreach. Efforts to address these challenges are already underway in some locations through public campaigns, awareness-raising programmes and partnerships with traditional and religious leaders.

Progress towards sustainability and scale

The expansion of the SARC model in Nigeria, from the establishment of the first centre in Lagos in 2013 to having SARCs at 52 sites across 25 states inclusive of the Federal Capital Territory by March 2026, demonstrates a strong commitment from both government and CSOs. Stakeholders agree that SARCs have become a vital component of the national response to sexual and gender-based violence, improving access to medical evidence, increasing community awareness and supporting implementation of the Violence Against Persons Prohibition Act.

The quality and resilience of the SARC workforce are central determinants of service effectiveness. Respondents highlighted that SARC teams, including doctors, nurses, counsellors and forensic examiners, demonstrate a strong commitment to supporting survivors. Medical and counselling staff receive training tailored to the SARC model, and ongoing learning is supported through national SARC Network conferences and peer-to-peer sharing platforms. At the same time, like many multidisciplinary models globally, SARCs face challenges related to staff workload, emotional strain and frequent transfers of government employees. Respondents emphasized the need to strengthen institutionalized well-being measures, noting that secondary trauma is an inherent risk in this work. These challenges present an opportunity for reinforcing professional development pathways and ensuring that staff feel supported and valued.

Nigeria's SARC model has made significant strides in expanding access to integrated, survivor-centred services for children and families affected by sexual abuse and exploitation, including that facilitated through technology. This reflects the commitment, innovation and determination of national stakeholders working under often challenging conditions to support child victims and survivors. Echoing findings in Bulgaria, the Philippines and South Africa, the model's success is influenced by broader systemic factors, including resourcing, staffing and interagency collaboration. However, the core design is strong, valued and adaptable. The findings from this study highlight substantial opportunities to deepen integration, expand national coverage, strengthen staff support and enhance responses to technology-facilitated sexual abuse.



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The way forward

The study identified the following critical success factors for strengthening the SARC model and multidisciplinary service provision for child victims and survivors of sexual abuse and exploitation in Nigeria. Detailed recommendations, co-created with national stakeholders, are presented in Annex I.



INTEGRATION:

Strengthen coordination between child protection services, social services, the health and education sectors and justice systems by institutionalizing joint protocols, referral pathways and regular communication mechanisms. Build on strong existing models, such as the approach followed by the Lagos Domestic and Sexual Violence Agency, to support more consistent multisector collaboration across all states and enhance child-centred service delivery.



STAFF CAPACITY AND SUPPORT:

Expand training and professional development for front-line workers, including medical staff, counsellors, forensic examiners, police officers, prosecutors, child interviewers and legal practitioners, with a focus on training in the area of trauma-informed care and technology-facilitated abuse. Establish structured staff well-being systems that include psychological support and regular supervision to reduce secondary trauma and strengthen the resilience of SARC teams.



SYSTEMS AND COORDINATION MECHANISMS:

Move beyond relationship-dependent coordination by co-creating and institutionalizing joint case management protocols, standard operating procedures and integrated referral mechanisms. Clarify roles and responsibilities across ministries and agencies to improve consistency, reduce delays and ensure that the Violence Against Persons Prohibition Act and related frameworks are translated into practical, survivor-friendly support services.



INNOVATION AND ADAPTATION TO THE DIGITAL AGE:

Build on emerging efforts to identify and respond to technology-facilitated child sexual exploitation and abuse by integrating routine questions about children's use of technology and online interactions, strengthening referral pathways that respond to both online and offline forms of abuse and developing specialized, evidence-based therapeutic approaches. Enhance staff knowledge of online risks and broaden the mandate of child protection technical working groups to encompass child online protection.



SUSTAINABILITY AND SCALE:

Expand and resource SARCs across all 36 states and the Federal Capital Territory by institutionalizing government budget allocations, embedding SARCs within primary health centres to broaden geographical reach and adopting a mixed government–CSO partnership model to sustain quality service delivery. Develop costed standards and systematic planning to support the continued equitable national roll-out of the model.



ACCESSIBILITY AND INCLUSION:

Address barriers such as stigma, the 'culture of silence', financial constraints and geographical distance through targeted outreach, stronger engagement with community and traditional leaders, and clear communication on available services. Ensure tailored approaches for children with disabilities, boys, LGBTQI+ youth and marginalized or underserved groups, and expand opportunities for child participation in feedback and service design.

The factors identified in Nigeria as being critical to success closely align with those identified in the other countries examined in this global study, namely Bulgaria, the Philippines and South Africa (*see Box 1*).

Box 1:

Key learnings from the global study on multidisciplinary models of care

1 **Integrate services through more than only co-location:** Success depends on strong cross-sectoral relationships, clear legal mandates, joint protocols and regular coordination mechanisms, not just physical proximity.

2 **Address technology-facilitated abuse systematically:** Services need tailored protocols, staff training and better pathways in law enforcement to support children experiencing technology-facilitated sexual abuse and exploitation.

3 **Embed models in national systems:** Effective models should be legally mandated, publicly funded and scaled equitably nationwide through planned government transitions with clear financial strategies.

4 **Centre children and community voices:** Children, families and communities should be involved in service design and improvement to ensure cultural relevance, accessibility and trust. Services must reach the most vulnerable.

5 **Support staff well-being:** Psychological supervision, peer support, realistic caseloads and stress management should be built into models to prevent burnout and sustain high-quality care, especially for psychosocial services providers.

6 **Monitor for learning and improvement:** Monitoring systems should be designed that capture child-centred outcomes, service quality feedback and emerging trends to continuously strengthen practice.

Source: Adapted from United Nations Children's Fund, *Multidisciplinary Models of Care: Strengthening services for child victims and survivors of sexual abuse and exploitation in the digital age,* UNICEF, New York, December 2025.



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1 Background

While using multidisciplinary service models is promoted as being good practice for supporting child victims and survivors of sexual abuse and exploitation,[4] evidence and information are generally lacking on service models' capacity to address the needs of children in low- and middle-income countries and to support children affected by sexual violence facilitated by technology.[5] The aim of this study was to generate evidence for policymakers and practitioners on good practice, to strengthen multidisciplinary working and offer improved care and outcomes for children and their families.

This report draws on findings from a rapid global literature review,[6] a country-level document review and fieldwork data collection in Nigeria. It is one of a series of four country reports and focuses on Nigeria's Sexual Assault Referral Centre (SARC) multidisciplinary service model. The study found that it is important to distinguish between the **form** of multidisciplinary models and their **function** in practice. Drawing on the experiences of child protection actors working within these models, the study examined both the opportunities and the constraints of multidisciplinary approaches.

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.[7] The methodology underwent ethical review by the Health Media Lab Institutional Review Board and received approval in April 2025. UNICEF Nigeria facilitated the data collection and coordinated logistics with national stakeholders in Nigeria, who generously collaborated with the research team during the study (*see Table 1*).

Table 1:
Data collection tools and respondents

Country	Key informant interviews	Survey responses	Focus group discussions	Documents reviewed
Nigeria	11	40	1	35

4 Radford, Lorraine, et al., *Action to End Child Sexual Abuse and Exploitation: A review of the evidence*, United Nations Children's Fund, New York, 2020, pp. 111–118.

5 Multidisciplinary Models of Care for Child Victims and Survivors.

6 Ibid.

7 The reference group, composed of external strategic partners within the child online safety ecosystem, was tasked with providing feedback on the implementation of the research at critical stages, including reviewing and providing feedback on the deliverables.

Key informant interviews and focus group discussions were conducted by an experienced research team of international and national researchers, with purposively selected key informants whose work directly relates to the SARC model. These included informants from state organizations and non-governmental organizations (NGOs). A desk review of relevant documents shared by UNICEF Nigeria and national stakeholders also contributed to the analysis. An online quantitative survey was administered to front-line service providers involved in implementing the SARC model to elicit perspectives from a broader range of stakeholders. The principles of informed consent, subject safety and confidentiality were adhered to in relation to all data collection. Information obtained through field data collection was triangulated and analysed alongside findings from the document review, which involved reviewing 35 sources (*see Annex II*).

For quality purposes, data collected by the national research team were cross-checked iteratively and analysed in several stages. The country-level data were first reviewed and consolidated by the research team and validated during workshops with national stakeholders, followed by further analysis by Child Frontiers to consolidate key findings. These findings were further reviewed and synthesized for this report to gain an understanding of the model and map the lessons learned, including opportunities for and challenges in supporting victims and survivors of child sexual abuse. The recommendations presented in the report were co-created with national stakeholders during a learning and reflection workshop held in Abuja on 9 October 2025. The report was finalized in consultation with UNICEF Nigeria.

Gaps and limitations

Study scope: The study had a relatively limited scope, with primary data collection having been undertaken at only a single SARC location in Nigeria. The global and national literature reviews were not intended to be exhaustive, and the level of detail was constrained by the study's time frame and scope and the existing evidence base. 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 and their families: The limited information gathered on children's and caregivers' perspectives was identified as a gap. The study drew on secondary sources, including findings of an examination of how service providers gather children's views on the relevance and effectiveness of services. Forthcoming research, including from Disrupting Harm project[8] and the Barnahus Network,[9] will contribute important information on children's and families' perspectives.



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8 More information can be found on the project web page (https://www.unicef.org/innocenti/projects/disrupting-harm).

9 More information can be found on the project website (https://barnahus.eu/).

2 Overview of the SARC multidisciplinary service model in Nigeria

Overview:
SARC model



Core team: This comprises doctors, nurses, forensic examiners and counsellors (provided by the Ministry of Women Affairs and Social Development).



Formal coordination mechanism: Formal coordination occurs via a steering committee composed of representatives from the three lead ministries: the Ministry of Justice, the Ministry of Health 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 to external partners, including the police and Social Welfare Department, as appropriate. Referrals are also made to civil society organizations (CSOs) and private service providers.



SARC staff: Each SARC should have a centre manager, a doctor, a nurse, a forensic examiner, counsellors, a receptionist, a finance officer and an administrative officer.



Location: The majority of SARCs are based in hospitals or medical centres, with some based in other locations.



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

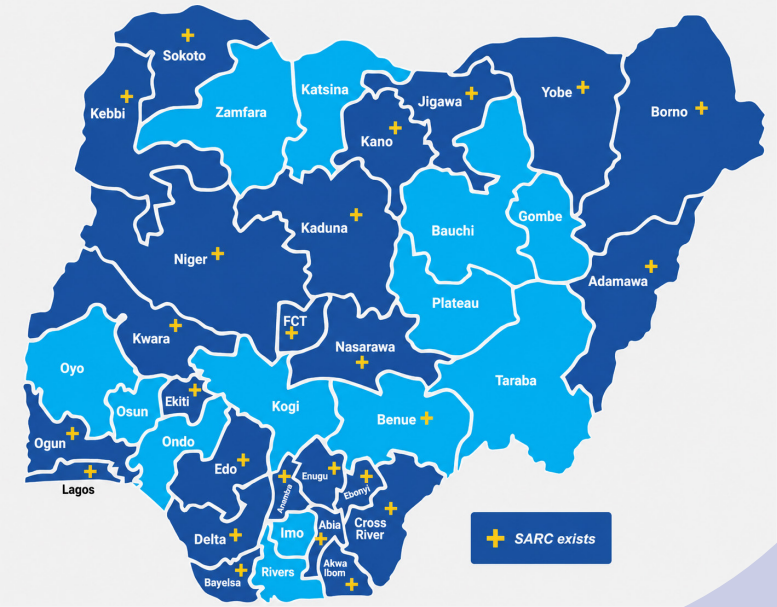
The SARC model was created to address the fragmentation and inadequacies of existing sexual assault response services identified in Nigeria to offer coordinated, survivor-centred care.[10] SARCs were designed to remedy long-standing systemic failures that denied both adult and child survivors access to justice and high-quality support. For example, difficulties were experienced in obtaining credible medical evidence, which contributed to low conviction rates. An overarching goal is to "limit the physical and mental health consequences of rape and sexual assault by providing free, accessible, multi-agency, forensically secured service for survivors".[11]

The Mirabel Centre, based in the state-owned Lagos State University Teaching Hospital, was the first SARC to be established in Nigeria. It was founded in 2013 by the NGO Partnership for Justice Nigeria with the support of the Justice for All Programme funded by the European Union, which later became the Rule of Law and Anti-Corruption Programme and is now the International Institute for Democracy and Electoral Assistance. The primary focus was to engage stakeholders across the Nigerian justice system to improve access to justice and personal safety for all citizens.

In 2015, the Government of Nigeria passed the Violence Against Persons Prohibition (VAPP) Act, establishing legislation designed to protect victims of various forms of violence, including sexual and gender-based violence, and to punish offenders.[12] This legal framework was supported by the establishment of special courts and a register of sexual offenders. According to respondents, the VAPP Act served as an important impetus for establishing additional SARCs across other states.

The Mirabel SARC was established following a visit of the founder Itoro Eze- Anaba who is a lawyer to St Mary's SARC in Manchester, United Kingdom, in 2003. St Mary's, the first SARC to be established in the United Kingdom, has provided sexual assault services to women, men and children since 1986, and offers training and awareness-raising sessions to professionals globally.

Figure 1:
SARC locations



Source: SARC Network Nigeria, Directory of Sexual Assault Referral Centres (SARCs) in Nigeria, March 2026, www.herstory.ng.

10 Sodipo, Oluwajimi O., Sekinat Odunaye-Badmus and Adejumo Olusola, 'Comparative Retrospective Review of Survivor and Perpetrator Profiles in Two Nigerian Sexual Assault Referral Centres: Implications for policy and protection', *Nigerian Health Journal,* vol. 25, no. 3, 2025, pp. 1229–1236, https://doi.org/10.71637/tnhj.v25i3.1172

11 Waziri-Azi, Fatima, National *Guide for the Establishment and Management of Sexual Assault Referral Centres in Nigeria*, European Union Rule of Law and Anti-Corruption Programme, 2023, https://naptip.gov.ng/download/national-guide-for-the-establishment-and-management-of-sexual-assault-referral-centres-in-nigeria/, accessed 13 May 2026.

12 Federal Government of Nigeria, Violence Against Persons (Prohibition) Act, 2015, Abuja, 2015, https://fida.org.ng/wp-content/uploads/2020/09/Violence-Against-Persons-Prohibition-Act-2015-1.pdf, accessed 13 May 2026.

As at March 2026, there were approximately 52 SARCs in Nigeria across the six geopolitical zones and 25 states, including the Federal Capital Territory (see Figure 1).[13] The SARC model involves multiple government agencies, including the ministries of women's affairs, health, justice, education and law enforcement. While most facilities are located in government hospitals to leverage existing health-care infrastructure and capacity, others are housed in primary health care centres, police clinics, nursing homes and juvenile correctional facilities. Respondents highlighted the advantages of hospital-based models, noting that hospitals' neutrality and openness to all provide survivors with anonymity. As medical reports from government hospitals are recognized by courts, the SARC model addresses the historical challenge of difficulties in obtaining sufficient medical evidence, strengthening legal cases and increasing the numbers of prosecutions and convictions under the VAPP Act and other laws.

> ***"Everybody in the hospital needs help. Everybody's sick one way or the other, so nobody points fingers at you when you enter [the] Mirabel Centre."***
>
> – Founder of the Mirabel Centre

The SARC model was designed to offer one-stop services for sexual assault cases by bringing together health-care providers, lawyers, law enforcement agencies and social welfare agencies. The core team offers medical examination and treatment along with psychosocial counselling to both child and adult survivors of sexual violence. Depending on the requirements of each case, access to legal services, law enforcement agencies and the judiciary, as well as to shelter, scholarships and nutritional support, is also provided through referrals to relevant ministries. It is recommended that each SARC be staffed with a centre manager, a doctor, a nurse, a forensic examiner, counsellors, a receptionist, a finance officer and an administrative officer.14 However, many government-managed SARCs reportedly operate with minimal staff, with implications for service delivery quality and staff well-being.

The study survey of SARC staff and other stakeholders indicated that the leading services provided are psychosocial care and therapy, and medical care. Family support and counselling, legal aid and community outreach services were also mentioned. Support for children who have experienced technology-facilitated abuse was less frequently mentioned. Respondents explained that SARCs function similarly to rape crisis centres. Some centres in Lagos extend additional support to families through empowerment programmes, scholarships and shelter referrals, alongside community awareness-raising campaigns.

13 States with SARC coverage: Adamawa, Akwa Ibom, Anambra, Bayelsa, Benue, Borno, Cross River, Delta, Ebonyi, Edo, Ekiti, Enugu, Federal Capital Territory (Abuja), Jigawa, Kaduna, Kano, Kebbi, Kwara, Lagos, Niger, Ogun, Sokoto, Yobe, Zamfara.

14 Waziri-Azi, *National Guide for the Establishment and Management of Sexual Assault Referral Centres in Nigeria*, p.7.

Resources and funding

Most SARCs currently operate under a hybrid funding system that combines external and state funding. The SARC initiative was initially funded from 2010 to 2017 by the UK Government's then Department for International Development. Currently, the European Union-funded Rule of Law and Anti-Corruption (RoLAC) Programme supports state governments in establishing and expanding SARCs across Nigeria. First implemented by the British Council between 2017 and 2022 and now in its second phase (2023–2027) under the International Institute for Democracy and Electoral Assistance, the RoLAC Programme provides financial and technical assistance to state governments to establish and sustain these centres. States are expected to contribute personnel and infrastructure and to provide ongoing operational funding. Costs for doctors, nurses and counsellors are supported by the state ministries of health and women's affairs. In some locations, SARCs are funded and run exclusively by CSOs working in the area of sexual and gender-based violence. The United Nations Children's Fund (UNICEF) has supported SARCs in six states by providing medical and information technology equipment, funding training and capacity-building activities, and raising awareness of SARCs among local communities.[15]

Government involvement and state responsibility have emerged as critical factors for the success and sustainability of SARCs.[16] This represents an important shift from the past, prior to the establishment of the SARC model, when NGOs were the primary service providers and funders in Nigeria. Despite this progress, government resource and capacity constraints have reportedly slowed the transition towards the full government leadership of SARCs.

Other multidisciplinary models also provide care to child victims of sexual abuse in Nigeria. For example, study respondents highlighted that the Cece Yara Child Advocacy Centre implements another service based on the Child Advocacy Centre model[17] in centres that were established in Lagos and Abuja in 2006, predating the SARC model. These centres offer multiple services in one location to child victims of sexual abuse and their non-offending family members, and children at risk, including a toll-free child helpline; legal, medical, psychosocial and shelter services; forensic interviewing services; and awareness-raising prevention training programmes.[18] While such private initiatives provide vital specialized care, the SARC model reflects Nigeria's national, multi-agency approach to responding to sexual and gender-based violence and operates on a scale that allows for system-level impact.

"If you put a SARC in a hospital that is poorly funded, how do you expect that the service will be delivered optimally? It's still the same doctors... the same nurses, it's still the same hospital facility. So, the SARC itself is trying to leverage off a system that is already faulty and that is where the challenges stem from."

– RoLAC Programme staff member

15 UNICEF Nigeria has provided financial support for SARCs in Bauch, Gombe, Katsina, Osun, Zamfara States and the Federal Capital Territory.

16 Ezeilo, Joy, 'An Overview of the SARC Model and How it Has Been Adjusted to Suit Context as Needed in Nigeria', Presentation, Sexual Assault Referral Network, Nigeria, n.d.

17 National Children's Alliance, 'The CAC Model', www.nationalchildrensalliance.org/cac-model, accessed 13 May 2026.

18 Cece Yara, 'About Us', www.ceceyara.org/about-us/, accessed 13 May 2026.

3 Integration of service delivery

Integration is essential for the effective implementation of multidisciplinary service models but requires more than the co-location of services or formal agreements. Effective integration depends on proactive coordination, clearly defined roles and shared commitment across agencies.[19]

The SARC model was designed as a one-stop facility through which survivors could access comprehensive support without having to navigate multiple service providers independently. Over 90 per cent of SARC staff and other stakeholders surveyed agreed that the model improves coordination among service providers. According to RoLAC Programme guidance on establishing a SARC, the first step is to secure 'buy-in' from all stakeholders, including the ministries of health, justice and gender/women's affairs, as well as the management board of the hospital where the SARC will be housed, and then to develop a memorandum of understanding formalizing the partnership agreement.[20]

Analysis across multidisciplinary models indicates that the location of the model directly influences the types of services offered, as well as the nature of collaborative work across services. Hospital- and medical centre-based models, such as SARCs in Nigeria, the Women and Children Protection Units in the Philippines, and the Thuthuzela Care Centres in South Africa, primarily provide health-care and medical forensic services but can face challenges in addressing legal, psychosocial and other dimensions of care. Models that are not implemented in healthcare facilities, such as the Zona ZaKrila model in Bulgaria, have difficulty coordinating with medical services but are able to effectively provide counselling and legal assistance.



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19 Multidisciplinary Models of Care: Strengthening services.

20 Rule of Law and Anti-Corruption Programme, Establishing a Sexual Assault Referral Centre (SARC): Critical considerations for state governments and line ministries, European Union and British Council, 2021, p.2.

While medical and psychosocial services appear to be well integrated in most SARCs, legal and judicial services are not directly provided within the model. 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. Respondents highlighted challenges related to the slow response of the judiciary and delays in obtaining forensic testing results due to the lack of rape test kits and the limited availability of DNA and forensic testing centres. Police investigators take statements at SARCs if they are located in the centres. In other cases, statements are taken at the police station before survivors are referred to the SARC. In cases where survivors first visit the SARC, they are referred to the police station for an interview and to provide a statement. However, coordination with law enforcement agencies beyond this initial stage is often reported to be weak.

The study found that the effectiveness of broader coordination among agencies involved in SARCs varies significantly by state. Respondents stated that integration works best in Lagos, where the Domestic and Sexual Violence Agency (DSVA) coordinates with various government agencies and NGOs to provide comprehensive services. These services include medical care, psychological support, legal assistance, community and child education, and advocacy. DSVA also maintains a sexual offenders list and a corresponding sexual offences court, which, according to respondents, tries cases promptly. In comparison, SARC services in other states are less well coordinated, particularly coordination with law enforcement agencies and the legal sector. Funding and other pre-existing systemic challenges appear to play a critical role in limiting the scope and integration of services offered to survivors of sexual assault.

When asked how children and women access SARC services, respondents frequently cited informal referral pathways, including community referrals and walk-ins. Some states, like Lagos, have formal protocols, such as the Unified Response Protocol and Referral Pathway mandated by the Lagos State DSVA under the Lagos State Ministry of Justice. Limited information was found on referral procedures or protocols; however, respondents described the following process for legal support and referrals:

- After a victim is referred to a SARC for a medical examination and treatment, law enforcement officials work to apprehend the suspect.
- SARC staff prepare and sign a document based on the medical examination, which serves as documentation for legal processes.
- The case file is presented to the State Ministry of Justice, which decides, based on the evidence, whether the Directorate of Public Prosecutions should take up the case.

Respondents stressed that, while the clinical management of sexual abuse is prioritized and immediate medical care is provided in SARCs, critical gaps exist in the provision of psychosocial support. In some locations, medical providers appear to be unwilling to treat the psychosocial dimensions of sexual assault because of the culture of silence around this form of violence in Nigeria. Survivors of sexual assault reportedly also face difficulties accessing law enforcement and judiciary services on account of challenges related to victim-blaming. In some cases, victims who seek assistance may be subjected to punitive sanctions rather than receiving supportive care.

"The gravity of sexual and gender-based violence is [that it is] a crime on survivors and the effect it has psychologically on them is often not acknowledged, and it's kind of dismissed."

– RoLAC Programme staff member

Establishing linkages with the education sector, particularly regarding referrals of student victims, has been a critical challenge for all the models studied.[21] School administrators and teachers are often the first to know if a child is being harmed or exhibiting behaviour that indicates problems at home or in other areas of their life. However, there often appears to be reluctance among members of school management to get involved in child protection issues, which are regarded as being the responsibility of law enforcement agencies and the courts. Nigerian respondents explained that, while schools sometimes refer children to SARCs, systematic linkages are unclear.

21 *Multidisciplinary Models of Care: Strengthening services.*

"One key relevance of the education sector in multidisciplinary models is the opportunity to sensitize a wide audience made up of school administrators, teachers and students on the availability of the services provided by the models and the referral pathways to access those services."

–UNICEF Nigeria Child Protection Specialist



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4 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.[22] Children affected by such violations often require specialized services and approaches.[23] Responding to technology-facilitated abuse can be particularly difficult in countries where child protection systems are constrained by capacity and resource limitations.[24]

Some respondents in Nigeria indicated that SARCs deal with technology-facilitated abuse, including cases of sexual extortion, cyberbullying, catfishing and the circulation of child sexual abuse material. However, more than a third of survey respondents reported being unaware of or unsure if these cases are handled by SARCs, indicating significant confusion about this issue.

Respondents explained that SARCs are not currently designed to identify or provide services for children affected by digital forms of abuse and that there is no routine screening for technology-facilitated abuse during intake. Sessions on basic technology-facilitated gender-based violence were held at a recent SARC Network conference organized by the RoLAC Programme, demonstrating the responsiveness of SARCs to emerging needs. However, beyond this event, systematic capacity-building support for service providers in responding to cases involving technology-facilitated sexual abuse has been limited. Slightly over half of the survey respondents (53 per cent) felt that SARC staff have sufficient capacity or knowledge to provide services to child victims of technology-facilitated sexual exploitation and abuse (*see Figure 2*).

22 Ibid., pp. 24–28.

23 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 of Online Sexual Abuse and Exploitation in the Philippines, UNICEF Philippines, Mandaluyong City, November 2023, https://www.unicef.org/philippines/reports/online-sexual-abuse-and-exploitation-philippines

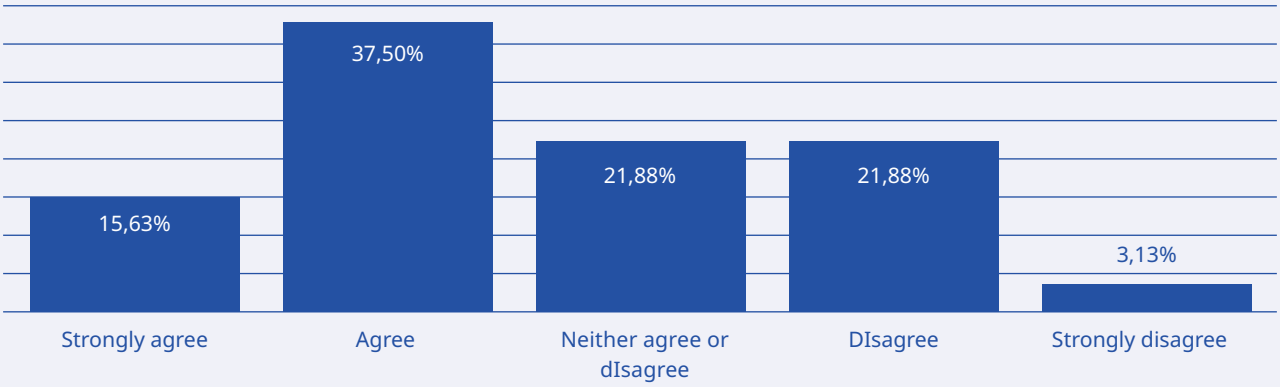
24 See the Disrupting Harm study for unique insights into how digital harms to children and young people are manifesting in 25 countries across six regions (https://safeonline.global/disrupting-harm/).

"SARC staff should be trained on technology-facilitated harm, how perpetrators conduct themselves, where to find help for victims and what services would be complementary to offline harm, knowing there could be connections between online and offline harm."

– Learning and reflection workshop participant, Abuja, 9 October 2025

Figure 2:

Responses to survey statement "SARC staff have sufficient capacity and knowledge to provide services to child victims and survivors of technology-facilitated sexual exploitation and abuse" (n = 40)



Source: SARC front-line staff survey, 2025.

When identified, cases of technology-facilitated abuse are reportedly referred to specialist organizations, including the Cece Yara Child Advocacy Centre and the Advocacy Against Abuse Initiative. The Mirabel Centre trains those responding to hotline calls in dealing with calls related to technology-facilitated sexual abuse, including suicide risks, and uses social media platforms to raise awareness about sexual and gender-based violence and the services offered by the SARC.

As with the multidisciplinary models investigated in other countries as part of this study, SARCs were designed to address in-person, contact forms of sexual violence. As such, SARCs operate without:

- routine screening for technology-facilitated abuse and exploitation during intake;
- specialized therapeutic approaches for technology-facilitated sexual abuse and exploitation;
- regular specialized training for multidisciplinary teams, especially front-line staff;[25]
- updated referral pathways for addressing technology-facilitated sexual abuse and exploitation;
- systematic recording of cases involving digital dimensions.

A common pattern across all countries is that technology-facilitated abuse cases come to services' attention primarily when they result in 'offline' harm or are linked to physical violence. Technology-facilitated abuse and exploitation (particularly livestreaming, sexual extortion or image-based abuse without physical contact) often goes undetected or unreported within these multidisciplinary models, representing a critical blind spot.

25 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 utilizing multidisciplinary approaches that ensure child safety and emotional stabilization. See for example Birgersson, Annette, and Linda S. Jonsson, *Crisis Intervention Guidelines and Protocol: Supporting child victims of online sexual abuse*, Council of the Baltic Sea States, 2025, https://barnahus.eu/2025/06/27/crisis-intervention-guidelines-and-protocol-supporting-child-victims-of-online-sexual-abuse/

5 Child-centred approach and community linkages

A child-centred approach requires services to provide support tailored to each child's age, gender, abilities and individual vulnerabilities. While multidisciplinary models aim to individualize care, the depth and consistency of how care is adapted to individual needs varies across locations.[26] The SARC model offers age-appropriate services, and staff receive specialized training in working with children, as confirmed by the majority (78 per cent) of survey respondents (*see Figure 3*). Respondents noted that SARCs in Lagos have access to sign-language interpreters through the Lagos State Office for Disability Affairs and can provide some support to children with speech impairments to facilitate access to services. Most survey respondents agreed that services are adapted to address children's specific vulnerabilities (72 per cent); however, such tailoring appears to be limited to visible disabilities and is based on broad age distinctions, and greater consistency in child-centred approaches across SARC sites is needed.

Targeted services and approaches for minority or refugee children appear to be largely absent. According to one stakeholder, differentiating service delivery based on a child's status or category, such as those based on disability, sexual orientation or refugee background, may be perceived as discriminatory. This perception may partially explain the absence of distinct or tailored interventions for specific groups. Outreach was highlighted as being essential for addressing stigma, the culture of silence and family-level interference, which obstruct reporting and access to justice. Respondents emphasized the importance of expanding community partnerships in improving accessibility, ensuring cultural relevance and building trust in services.

The global literature review found limited information on the capacity of gender-based violence models to address children's unique needs.[27] Three of the models studied serve both women and children, including the SARC model.[28] Using the same model to support both adults and children can create operational challenges, including competition for limited resources and gaps in specialized, child-focused services. During the learning and reflection workshop held with national stakeholders in Abuja to review the study findings, participants noted that, while most SARCs serve children, tailored service provision and materials to support child-centred care and approaches remain limited.

26 Multidisciplinary Models of Care: Strengthening services, pp. 24–28.

27 Multidisciplinary Models of Care for Child Victims and Survivors, p.18.

28 The Philippines' Women and Children Protection Unit, South Africa's Thuthuzela Care Centres and Nigeria's SARCs.

6 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 in multidisciplinary models.[29] In Nigeria, it is standard practice for all SARCs to collect basic service data on the types of services provided and the number of people accessing them. These data are shared with the RoLAC Programme. Some SARCs use checklists to monitor service provision and conduct peer reviews and daily staff check-ins. External evaluations are dependent on the availability of resources. For example, the Mirabel Centre paused its external evaluation process after three years owing to a lack of finances. In the absence of external funding for monitoring and evaluation, quarterly meetings are used as opportunities to reflect on accomplishments and challenges encountered. Respondents could not say for certain whether the data collected are used for long-term policy development or to improve programme design. Similarly, the interviews did not identify whether the collected data are used for planning and budgeting purposes.

To support quality assurance, RoLAC Programme personnel visit SARCs monthly for observation and mentoring purposes and also arrange for the staff of struggling SARCs to visit more successful centres for learning and technical support purposes. User feedback is collected through post-service forms, suggestion boxes, hotlines, follow-up calls and survivor forums. Families generally report through these mechanisms that services are helpful, confidential and reduce trauma. In practice, SARCs are expected to convene quarterly or biannual gatherings to obtain feedback from former service users. It has not been possible to consistently implement survivor forums because of funding constraints, although respondents stated that these sessions are useful when conducted.

> ***"The best interest of the child is not that of an adult making decision[s] for children."***
>
> – Learning and reflection workshop participant, Abuja, 9 October 2025

Where feedback is available, it is mainly collected from caregivers rather than directly from children, even though children account for 70–80 per cent of cases in SARCs such as the Mirabel Centre, limiting child-centred evaluation. This was a common finding across all multidisciplinary models studied, with staff citing conflicts between evaluation demands and limited capacity to undertake additional assessment tasks.[30] Concerns about unintentionally retraumatizing children and families through repeated follow-up for evaluation purposes were also noted as a deterrent factor.

29 Multidisciplinary Models of Care for Child Victims and Survivors, p.37. For example, of the 28 countries studied with Barnahus or Barnahus-type services in place, only 6 (Denmark, Finland, Norway, Poland, Spain and Sweden) reported evaluating services (see Greijer, Susanna, and Daja Wenke, 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, Strasbourg, 2023, pp. 85–88).

30 Multidisciplinary Models of Care: Strengthening services.

7 Service provider support and capacity-building

Greater supervision and support for professionals working with children affected by violence were identified as critical needs across all of the multidisciplinary models studied.[31] Respondents highlighted a number of SARC initiatives focused on ensuring staff well-being, facilitating professional development and optimizing the organizational structure to better support survivors. Staff receive mental health first-aid training and psychological support, with efforts also under way to improve consistency. Debriefings with supervisors are held to support staff in effectively managing cases. Following the initial SARC staff training conducted by staff of St Mary's SARC in Manchester, United Kingdom of Great Britain and Northern Ireland, in 2013 and an additional training session for staff of newly established SARCs in 2015, a core group of national medical and counselling trainers, with responsibility for training and retraining new and existing SARC staff, was formed.

Medical and counselling personnel recruited to work at SARCs participate in an initial five-day training course to equip them with the knowledge and skills needed to deliver services under the model. While the aim is for all front-line workers to receive regular training and support to promote their resilience, in practice mental health support for staff is limited despite the significant challenges they face. High levels of emotional stress and burnout are reportedly common among front-line professionals working under the SARC model with challenging cases of sexual abuse and exploitation.

31 *Multidisciplinary Models of Care for Child Victims and Survivors*, p. 42.

"[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 to deal with it. So that became a major ... issue."

– Founder of Mirabel SARC

Staff capacity development strategies include continuous professional development programmes and the establishment of platforms for knowledge-sharing among SARCs across locations. Frequent staff transfers, something that is typical of the Nigerian medical system, and the loss of skilled personnel to private hospitals were noted as challenges, and the ongoing training and retraining of SARC team members is required to address these challenges. In some cases, trained personnel from one SARC are asked to work in SARCs in other states for short periods to cover staffing gaps when necessary.[32]

SARC Network conferences organized by the RoLAC Programme are designed to share lessons learned and promote dialogue among SARCs, government institutions and other stakeholders to strengthen services for survivors. 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 and Social Development, the National Agency for the Prohibition of Trafficking in Persons, the International Institute for Democracy and Electoral Assistance, and CSOs. The study team attended one of these national conferences remotely and experienced first-hand the dynamic exchange of learning and experience among staff from SARCs nationwide. These valuable opportunities to openly and collectively voice challenges offer effective ways of exploring and identifying contextually appropriate strategies for multidisciplinary service provision.

32 Rule of Law and Anti-Corruption Programme, *How to Set Up a Sexual Assault Referral Centre*, European Union and British Council, n.d., p. 7.



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8 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.[33] However, the gap between aspiration and reality remains substantial, particularly in resource-constrained environments. Nigeria's SARC model demonstrates both the potential and the practical challenges of implementing multidisciplinary approaches at scale, offering valuable lessons for strengthening child protection systems globally.

The expansion of the network of SARCs from 1 centre in 2013 to 52 across 25 states as at March 2026 demonstrates a strong commitment from both government and CSOs. Yet, achieving the vision of having 774 SARCs in every local government area, as articulated by Professor Joy Ngozi Ezeilo, Chairperson of the Sexual Assault Referral Centres Network, will require fundamental questions of sustainability, coordination and equitable access to be addressed. Cultural stigma, financial constraints and geographical distance create substantial barriers.

National stakeholders emphasized that the optimal approach for Nigeria's context is a mixed partnership model combining government agencies and CSOs, with CSOs providing technical expertise and government agencies ensuring sustainability and institutional commitment, including support for infrastructure, equipment and staffing. Effective coordination depends on structured processes, including frequent coordination meetings, joint case conferences and shared protocols that ensure alignment at both the technical and policy levels.

SARCs are increasingly encountering technology-facilitated abuse, including sexual extortion, cyberbullying and the circulation of child sexual abuse material. While systematic approaches are still being developed, integrating specialized therapeutic responses and updated referral pathways into the existing model will be essential as children's realities evolve.

SARC teams demonstrate strong commitment, but face challenges related to workload, emotional strain and frequent staff transfers. Strengthening institutionalized well-being measures and ongoing capacity-building will help to ensure that staff feel supported and valued. Enhancing data systems to capture child-centred feedback, trends in technology-facilitated abuse and service quality indicators will ensure that SARCs continue evolving in response to children's needs.

Ultimately, the way forward lies in consolidating what works, addressing persistent systemic barriers and investing in foundational elements that enable coordinated responses to function effectively at scale. With continued commitment, investment and adequate resourcing, leadership and cross-sectoral collaboration, the SARC model will continue evolving into a fully embedded, sustainable national service that delivers high-quality, child-centred care across all states of Nigeria.

33 Multidisciplinary Models of Care for Child Victims and Survivors, p. 45.

Annex I:
Recommendations

National level: Government partners

Ensure sustainable funding and resources

- Continue to promote strategic partnerships with government line ministries to ensure sustainability. CSOs and service providers should be encouraged to establish formal partnerships with relevant government ministries to secure institutional support and ensure financial sustainability.

- Integrate SARC-related initiatives into existing ministerial budget lines, such as those of the ministries of health, justice and women's affairs, gender and/or children's affairs (depending on the ministry in each state assigned to oversee SARCs), to enhance ownership, continuity and long-term impact.

- Advocate for the statutory establishment of SARCs in primary health centres in each local government area to expand reach to rural communities. This would broaden access for survivors across rural areas in all 36 states and the Federal Capital Territory, ensuring that SARC services are decentralized, community based and responsive to the needs of survivors.

Policy and legal improvements

- Amend the VAPP Act to include technology-facilitated abuse provisions. Integrating relevant sexual and gender-based violence provisions into the ongoing amendments of the Child's Right Act and the VAPP Act will help to harmonize legislation, reduce policy fragmentation and strengthen alignment with the SARC coordinated response framework.

- Develop comprehensive national child online protection legislation and policy to prevent harm to children in the digital space, provide accessible reporting channels, enhance service provision for survivors, including by SARCs, and strengthen the capacity of law enforcement agencies to detect and ensure the take-down of child sexual abuse materials and arrest and prosecute perpetrators, including in cases involving technology-facilitated harm.

Improve interagency coordination

- Strengthen and institutionalize coordination mechanisms among entities, particularly sectors. Coordination frameworks must be inclusive of all relevant service providers and not limited to law enforcement and social welfare agencies. Health, legal, psychosocial, education and community-based actors should be systematically integrated into coordination mechanisms to ensure a comprehensive, survivor-centred response within the SARC framework.

- Establish integrated pathways for referral between service systems. Develop and institutionalize referral mechanisms to enable seamless coordination between service delivery channels, to ensure that survivors receive timely and appropriate support regardless of where the abuse originated or was reported.

- Strengthen collaboration with line ministries to address existing gaps and inconsistencies in implementation, particularly by ensuring that sexual and gender-based violence desks are fully functional, coordinated and aligned with national response standards under the SARC model.

- Strengthen and empower the existing National Steering Committee on Gender-Based Violence, co-chaired by the Federal Ministry of Women Affairs and Social Development and the Federal Ministry of Justice. Reinforcing this mechanism will promote policy coherence, enhance accountability and ensure more effective coordination among all actors within the SARC framework.

- Establish SARC coordinating committees composed of representatives from relevant institutions – including the ministries of health, justice and women's affairs, gender and/or children's affairs, the police and the Office of the Prosecutor, CSOs and SARCs – that meet regularly to discuss challenges, service delivery and referrals.

Specialized courts and justice linkages

- States should establish specialized sexual and gender-based violence courts that are integrated into the SARC framework, ensuring that prosecutors and judicial and law enforcement personnel receive continuous capacity-building training on child-sensitive, survivor-centred and trauma-informed approaches. Strengthened state-level advocacy and institutional support mechanisms will be essential for sustaining these reforms and ensuring the coordinated delivery of justice for survivors.

- Establish fast-track courts for sexual offences to reduce case backlogs.

- Expand access to DNA and forensic testing and reform evidentiary laws to strengthen the evidence base for prosecutions and improve access to justice for survivors.

Operational level: SARC implementing organizations

Strengthen staff training and capacity-building

- Provide regular capacity-building and mentoring support for service providers through public and private partnerships.

- Strengthen the capacity of SARC personnel to deal with cases of technology-facilitated abuse and its links with offline harm. SARC staff should receive specialized training, focused on building understanding of patterns of online perpetration, identifying suitable referral pathways and providing appropriate support to survivors.

- Integrate screening for online abuse into survivor assessment processes. Standardize initial survivor assessments and intake procedures to include questions designed to determine whether the abuse or exploitation originated or was facilitated online.

Strengthen systems

- Focus on enhancing the effectiveness of abuse response systems, rather than merely connecting existing structures, to ensure real-time coordination, data-driven case management and seamless referral pathways within the SARC framework.

- Strengthen multidisciplinary integration with the education sector, as teachers are often the first to notice changes in children, and raise awareness among the sector of the services available.

Staff support and well-being

- Amend staff guidelines to include mandatory mental health and well-being support programmes for front-line workers, including counselling and debriefing sessions, through partnership with private and public service providers.

Enhance access and inclusion

- Expand services to reach rural areas and minority communities, addressing geographical barriers compounded by high transport costs and lack of awareness.

- Develop specialized approaches for children with disabilities, boys, LGBTQI+ youth and marginalized or underserved groups, ensuring access to tailored services that address the specific vulnerabilities of these groups and the barriers they face to accessing support, while also protecting them from potential discrimination and harm.

Strengthen monitoring and evaluation

- Enhance data systems to capture child-centred feedback, trends in technology-facilitated abuse and service quality indicators to ensure that services provided by SARCs continue to evolve in response to children's needs.

- Strengthen mechanisms for collecting feedback directly from children and their families, moving beyond parent-only feedback to ensure genuine child participation in service evaluation.

- Continue to leverage RoLAC /International Institute for Democracy and Electoral Assistance SARC Network conferences as platforms for peer learning, sharing challenges and collectively identifying contextually appropriate strategies for strengthening multidisciplinary service provision.

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