

InSupport

Enhancing Interagency Support for Victims of Sexual Violence

symplexis

Standard Operating Procedures for Healthcare Professionals & Services

Supporting women survivors of sexual violence

Project Number: 101195372



Co-funded by
the European Union

Document information	
Work Package	WP3 – Enhancement of victim response and support procedures of law enforcement and frontline services
Task	T3.2 Development of Protocol/SOPs for healthcare services
Deliverable	D3.2 - Protocol/SOPs for healthcare services
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Proofreading	WHO Office on Quality of Care and Patient Safety, Athens, Greece (Jeniffer Hall, Anastasia Giannaki, Nefeli Romanou, Nurshaim Tilenbaeva, Panagiota Kalpaxi) Forensic Medical Service of the Dodecanese
Dissemination level	Public
Summary	In the high-stakes intersection of medicine and the law, the healthcare professional is frequently the initial conduit between a survivor's trauma and their pursuit of justice. This document, produced as part of the EU-funded “InSupport” project, offers a comprehensive guide for frontline professionals—emergency clinicians, general practitioners, and mental health specialists—addressing the intricacies of sexual violence in modern Greece. This manual goes beyond clinical theory and is based on the big change toward a legal system based on consent and the most recent changes in 2025. It gives a useful, trauma-informed framework for every part of the interaction, from the first iterative consent and the “LIVES” model of psychological first aid to the technical challenges of collecting forensic evidence (SAEK) and making referrals to multiple agencies. It is designed to fit the reality of the Greek healthcare system and makes clear the delicate balance between mandatory reporting and professional secrecy, so that doctors can act with “care and courage”. This guide makes sure that no woman is met with institutional silence by focusing on survivor autonomy and intersectional sensitivity, including specific rules for victims of “corrective” rape. It is not just a set of rules; it is an important set of tools for making sure that clinical intervention is a key part of healing, respect, and human rights.
Date (Publication)	12/03/2026



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Funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Commission. Neither the European Union nor the European Commission can be held responsible for them. [Project Number: 101195372 — InSupport — CERV-2024-DAPHNE]

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ACKNOWLEDGEMENTS

The author and NGO Symplexis wish to express their sincere appreciation to the team of the WHO Office on Quality of Care and Patient Safety in Athens - Jeniffer Hall, Anastasia Giannaki, Nefeli Romanou, Nurshaim Tilenbaeva, and Panagiota Kalpaxi – and the Forensic Medical Service of the Dodecanese for their prompt response to our request and for their valuable feedback and critical review of this publication.

Their thoughtful comments, constructive observations, and expert insights made an important contribution to the further improvement of the present edition, significantly enhancing its quality, clarity, and practical relevance.

INTRODUCTION: A New Paradigm for Clinical Response

The healthcare setting frequently serves as the initial—and occasionally sole—point of contact for female survivors of sexual violence. In these important times, how a professional reacts can either help people heal and get justice or make the trauma worse without meaning to. Acknowledging this substantial obligation, this publication signifies a notable advancement in the clinical management of sexual violence against women in Greece.

This document is a deliverable (Task 3.2, deliverable 3.2) for the “InSupport” project [Project Number: 101195372 — InSupport — CERV-2024-DAPHNE]. It was funded by the European Union's Citizens, Equality, Rights and Values Programme (CERV). The NGO Symplexis was in charge of the whole “InSupport” project, including its design and development.

This publication is not independent. It is a proud successor to and builds on the work that the Research Center for Gender Equality (KETHI) did. The *Guide for Health Professionals on Violence Against Women*, which KETHI published in 2020, was a key resource that made the Greek medical community more aware of the issue. This new set of SOPs builds on that legacy by including the major legal changes of 2024 and 2025 and giving practitioners more detailed, step-by-step clinical instructions.

Structure of the Protocol: The Clinical Journey

This publication is divided into three parts that follow the real-life clinical journey of a survivor. This is to make sure that the care they receive is of the highest quality. This structure makes it easy for healthcare workers to quickly switch between basic information and urgent, action-oriented tasks.

Phase 1: Foundations

Establishing the “Why”, “What”, and “Where” before a survivor arrives.

These sections provide the essential knowledge and ethical baseline required to handle sensitive cases of sexual violence.

1. **Key Concepts and Definitions:** Establishes a shared, scientifically rigorous vocabulary, including specific terminology for modern challenges like “corrective” rape and stealthing.
2. **National (Greek) Legal Framework:** A vital “legal compass” detailing the 2025 reforms, the consent-based model of rape, and the mandatory reporting duties of healthcare staff.
3. **Guiding Principles and Code of Conduct:** Outlines the ethical “LIVES” framework and the behavioral standards required to maintain survivor autonomy.
4. **Health Facilities Minimum Standards:** Defines the infrastructure and medical supply requirements - such as 24/7 access to PEP and EC - necessary for a facility to be technically and ethically “ready”.

Phase 2: The Acute Encounter

A sequential, trauma-informed response during the clinical visit.

These sections follow the chronological steps of the encounter, prioritizing survivor autonomy and forensic integrity.

5. **Consent and Information Sharing:** The “gatekeeper” of the encounter; establishes the standard for iterative, granular consent.
6. **Risk Assessment and Addressing Needs:** Provides a multi-dimensional tool for rapid triage, evaluating immediate lethality and systemic barriers to safety.
7. **Interviewing Survivors:** Focuses on trauma-informed communication and the neurobiology of fragmented memory to build rapport and obtain a narrative.
8. **Examination and Care of Physical and Emotional Health:** Addresses the biopsychosocial needs of the survivor, treating physical injury and emotional distress as a single clinical priority.
9. **Medical Assessment and Physical Evidence (SAEK):** A technical guide to the forensic “rape kit” process, emphasizing the “pilot” principle where the survivor remains in control.
10. **Documentation and Reporting:** Offers a standardized framework for creating objective, legally defensible medical-legal records to support future justice processes.

Phase 3: Aftercare and Continuity

Focusing on the survivor’s journey beyond the facility walls.

The protocol/SOPs conclude(s) with the longitudinal tracks necessary to prevent survivors from "falling through the cracks" of the support system.

11. **Follow-up Care:** Details the tracks for medical monitoring (STIs/HIV) and psychological recovery beyond the acute phase.
12. **Referral Paths:** Provides a roadmap for the "warm handover" to specialized NGOs, legal aid, and justice services.

Appendices: The Resource Directory

The protocol/SOPs conclude(s) with two specialized Toolkits designed for immediate field use:

- **Annex 1 – Support Services Directory:** A comprehensive, categorized list of psychosocial and legal support structures, including the counselling centers for women, helplines, specialized NGOs and the Greek Orthodox Church.
- **Annex 2 – National Forensic Services Map:** A detailed directory of Forensic Services across Greece with verified contact details to facilitate urgent referrals.
- **Annex 3 – Police Response & Protection Directory:** A specialized mapping of **Security Departments** (“Τμήματα Ασφάλειας”) and **Domestic Violence Response Offices** of the Hellenic Police. This section details primary emergency lines (**100** and **15900**) and outlines access to enhanced protection measures, including the “**Panic Button**” application and the network of “**Safe Houses**” for survivors at high risk of lethality.

As a healthcare professional, your responsibilities encompass more than the immediate management of physical injuries. You are the most important link in a chain of safety. You make sure that no woman has to deal with the effects of sexual violence on her own by following the Standard Operating Procedures in this publication and using the specialized resources in the **Annexes**.

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PHASE 1: FOUNDATIONS

1. Key concept and definitions

1.1. Purpose and scope

The purpose of this section is to provide health professionals with a comprehensive and standardized terminological framework for identifying and categorizing various forms of sexual violence. Given that survivors may present with physical injuries, psychological distress, or reproductive health crises, it is essential for practitioners to understand the specific legal and social definitions that inform the care pathway.

The scope of these definitions covers:

- **Legal Frameworks:** Aligning clinical practice with the Greek Penal Code and the Istanbul Convention.
- **Institutional Standards:** Incorporating definitions from the United Nations, the Council of Europe, EU's secondary law (Directives), the International Criminal Court, the European Institute for Gender Equality (EIGE) and Eurostat.
- **Specialized Phenomena:** Defining complex issues such as "corrective" rape, stealthing, and conflict-related sexual violence to ensure that marginalized or specifically targeted groups receive appropriate, trauma-informed care.

By utilizing these definitions, health professionals can improve the accuracy of medical documentation, facilitate legal advocacy when requested by the survivor, and provide a higher standard of integrated support that acknowledges the intersectional nature of gender-based violence.

1.2. Glossary of terms

- **Acquaintance rape:** see "Date rape".
- **Conflict-related sexual violence (CRSV):** This term refers to rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict. That link may be evident in the profile of the perpetrator, who is often affiliated with a State or non-State armed group, which includes terrorist entities; the profile of the victim, who is frequently an actual or perceived member of a political, ethnic or religious minority group or targeted on the basis of actual or perceived sexual orientation or gender identity; the climate of impunity, which is generally associated with State collapse, cross-border consequences such as displacement or trafficking, and/or violations of a ceasefire agreement. The term also encompasses trafficking in persons for the purpose of

sexual violence or exploitation, when committed in situations of conflict” (United Nations, 2019:3).

- **Consent:** “Consent refers to voluntary agreement as the result of a person’s free will” (EIGE, n.d.).
- **“Corrective” rape:** “Corrective” rape is defined as a specific manifestation of hate-motivated sexual violence characterized by the perpetrator’s intent to “cure”, “punish”, or “rehabilitate” individuals who do not conform to traditional heteronormative gender roles or sexual orientation norms (Gaitho, 2022; Hlongwane, 2016). This practice is recognized as a violent mechanism of social control used to enforce heteropatriarchal hierarchies and “teach a lesson” to those perceived as socially deviant (Doan-Minh, 2019). Rather than being viewed solely as a sexual offense, it is framed as a political and systemic act of discrimination where sexual assault is weaponized to police gender presentation and identity (Doan-Minh, 2019).
- **Forced abortion:** Forced abortion refers to “an abortion on a woman without her prior and informed consent” (Council of Europe, 2011a, Article 39). “The termination of pregnancy covers any of the various procedures that result in the expulsion of all the products of conception” (Council of Europe, 2011b, Article 39).
- **Forced pregnancy:** “forced pregnancy is a “crime against humanity” that refers to “the unlawful confinement of a woman forcibly made pregnant, with the intent of affecting the ethnic composition of any population or carrying out other grave violations of international law” (International Criminal Court, 2021, Article 7). This act “is a serious violation of sexual and reproductive rights and autonomy” and, “like all sexual and gender-based human rights violations, it can cause severe physical and psychological harms and often has lasting personal, social and economic consequences” (Amnesty International, 2020:4).
- **Forced sterilization:** Forced sterilization refers to a “surgery which has the purpose or effect of terminating a woman’s capacity to naturally reproduce without her prior and informed consent or understanding of the procedure” (Council of Europe, 2011a, Article 39). “The term sterilization refers to any procedure which results in the loss of the ability to naturally reproduce” (Council of Europe, 2011b, Article 39).
- **Gender:** Gender “is defined as the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men” (Council of Europe, 2011a, Article 3).
- **Gender-based violence (GBV) against women:** GBV against women “refers to all violence directed against a woman because she is a woman or that affects women disproportionately” (Council of Europe, 2011a, Article 3).
- **Date rape:** According to EIGE (n.d.), this term refers to
 Non-consensual vaginal, anal, or oral penetration of the body of another person where the penetration is of a sexual nature, with any bodily part or with an object, by an acquaintance or dating partner of the rape victim. (...) Date rape also refers to any other non-consensual acts of a sexual nature. Causing another person to engage in non-consensual acts of a sexual nature with a third person is also considered as date rape. This type of rape is also called acquaintance rape.
- **Date-rape drugs:** See “Drug-Facilitated Sexual Assault (DFSA)”.
- **Domestic violence:** This term refers to “all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim” (Council of Europe, 2011a, Article 3).
- **Drug-Facilitated Sexual Assault (DFSA):** DFSA refers to incidents where an individual is subjected to sexual acts while their capacity to resist or provide valid consent is significantly impaired due to the effects of alcohol (ethanol), narcotics, or other psychoactive substances.

In this context, the so-called “date-rape drugs” can induce sedation, disorientation, and/or amnesia, rendering the victim more vulnerable, as they may be unable to resist or exercise free will (Office on Women’s Health [OWH], n.d.; United Nations Office on Drugs and Crime [UNODC], 2011). These substances can be administered in two primary ways: a. Surreptitious administration - the substance is given to the victim secretly / clandestine drugging, b. exploitation of voluntary consumption - the perpetrator takes advantage of the victim's state of vulnerability following the voluntary consumption of a substance, most commonly alcohol (UNODC, 2011).

- **Rape:** Under Greek law (Article 336 of the Penal Code, as enacted by Law 4619/2019 and currently in force), rape is defined as the “coercion” of a person “to perform or tolerate a sexual act” through “physical violence or the threat of serious and immediate danger to life or physical integrity”. A “sexual act” encompasses “sexual intercourse and acts of equal gravity”, while any such act performed “without the victim's consent” also constitutes rape. In other words, establishing rape does not require proof of physical resistance, bruising, or the use of a weapon; the absence of genuine consent is sufficient.
- **Sexual assault:** “Sexual assault means an unwanted sexual act — except rape — as a result of physical force, threat, coercion, intimidation, deception, drugs/alcohol, or abuse of vulnerability” (Eurostat, n.d.).
- **Sexual harassment:** Sexual harassment refers to “any form of unwanted verbal, non-verbal or physical conduct of a sexual nature occurs, with the purpose or effect of violating the dignity of a person, in particular when creating an intimidating, hostile, degrading, humiliating or offensive environment” (Directive 2006/54/EC, 2006, Article 2).¹
- **Sexual violence:** This term refers to “all forms of sexual acts which are performed on another person without her or his freely given consent and which are carried out intentionally” (Council of Europe, 2011b, Article 36). More specifically, the Istanbul Convention explicitly refers to three “intentional conducts”:
 - a. engaging in non-consensual vaginal, anal or oral penetration of a sexual nature of the body of another person with any bodily part or object;
 - b. engaging in other non-consensual acts of a sexual nature with a person;
 - c. causing another person to engage in non-consensual acts of a sexual nature with a third person (Council of Europe, 2011a, Article 36).

Such acts include “acts of abusive sexual contact, forced engagement in sexual acts, attempted or completed sexual acts with a woman without her consent, sexual harassment, verbal abuse, threats, exposure, unwanted touching, incest, etc.” (United Nations Department of Economic and Social Affairs Statistics Division, 2014:16). “A minimum list of acts of sexual violence” includes rape, attempted rape, as well as other sexual acts such as:

- Intimate touching without consent
- Sexual acts other than intercourse forced by money
- Sexual acts other than intercourse obtained through threats of physical violence
- Sexual acts other than intercourse obtained through threats to the well-being of family members
- Use of force or coercion to obtain unwanted sexual acts or any sexual activity that the female partner finds degrading or humiliating
- Other acts of sexual violence (United Nations Department of Economic and Social Affairs Statistics Division, 2014:16).

¹ The transposition of Directive 2006/54/EC into Greek national legislation was achieved through Law 3896/2010.

- **Stealthing:** Stealthing refers to “nonconsensual condom removal during sexual intercourse” (Brodsky, 2017:183). It is a “practice’ that “puts partners at risk for unwanted pregnancies and sexually transmitted infections (STIs) and, survivors explain, it feels like a violation of trust and a denial of autonomy, not dissimilar to rape” (Brodsky, 2017:184). This practice “is a harmful and often gender-motivated form of sexual violence” (Brodsky, 2017:210).
- **Survivor:** The terms “survivor” and “victim” are “often used interchangeably” concerning “violence against women” (EIGE, n.d.). Nevertheless, “the term victim has been subject to criticism as it denies agency to women subjected to gender-based violence, in particular victims of rape” (EIGE, n.d.). The term “survivor” aligns with a “survivor-centered approach” which “places the human rights, needs and desires of women and girl survivors as the central focus of service delivery” (UN Women, 2022:8).
- **Trafficking (including Sex Trafficking):** Trafficking refers to the recruitment, transportation, transfer, harbouring or reception of persons, including the exchange or transfer of control over those persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation (Directive 2011/36/EU, 2011, Article 2).
This exploitation shall include, as a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, including begging, slavery or practices similar to slavery, servitude, or the exploitation of criminal activities, or the removal of organs, or the exploitation of surrogacy, of forced marriage, or of illegal adoption (Directive 2011/36/EU, 2011, Article 2 as it was amended by Directive 2024/1712, 2024, Article 2).
- **Victim:** see “Survivor”.
- **Violence against women (and girls):** Violence against women “is a human rights violation and a form of discrimination against women. “Violence against women” refers to all acts of violence that result in, or are likely to result in physical, sexual, psychological or economic harm or suffering to women, including threats, coercion or arbitrary deprivation of liberty, whether occurring in public or private spaces” (Council of Europe, 2011a, Article 3).

In more detail,

Violence against women shall be understood to encompass, but not be limited to, the following:

- a. Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- b. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- c. Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs (UN General Assembly, 1993, Article 2).

The adoption of the comprehensive term “Violence Against Women and Girls” (VAWG) instead of the more limited “Violence Against Women” reflects a strategic commitment to a life-cycle approach in addressing gender-based violence, recognizing that the structural inequality and risks faced by females form a continuum that begins in childhood. As stated in paragraph 41 of the Beijing Declaration and Platform for Action, “The girl child of today is the woman of tomorrow,” and her empowerment depends on being nurtured in an enabling environment where her “spiritual, intellectual and material needs for survival, protection and development are met and her equal rights safeguarded” (United Nations, 1995, para. 41). Crucially, the same paragraph underscores why “and girls” cannot be treated as a cosmetic add-on: it notes that discrimination and violence against girls begin at the earliest stages of life and continue throughout their lives, and it explicitly points to forms of sexual and economic exploitation and harmful practices—such as female genital mutilation and early/child marriage—that target female individuals before they reach legal adulthood (United Nations, 1995, para. 41). Therefore, explicitly including “girls” in the term VAWG helps ensure that policies, institutional responses, and referral structures are designed to address age-specific vulnerabilities and prevent harm before adulthood, safeguarding girls’ development as a necessary precondition for women’s equal partnership with men and for substantive gender equality.

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2. National (Greek) legal framework

2.1. Purpose and scope

The primary objective of this section is to equip healthcare providers with a clear, actionable "legal map" of the Greek penal and procedural environment. In a field where professional secrecy is a cornerstone of the patient-provider relationship, recent legislative reforms have introduced specific exceptions and mandates that are designed to prioritize the immediate safety of vulnerable individuals.

The scope of this section includes:

- **Defining the Consent Model:** Clarifying the transition to the "No means No" (and "Silence means No") framework established by Laws 4619/2019 and 5090/2024.
- **Outlining Mandatory Reporting:** Detailing the specific statutory obligations under Law 5172/2025 that require professionals to report indications of violence, particularly concerning minors and domestic abuse.
- **Upholding Victims' Rights:** Translating the procedural safeguards of Law 4478/2017 into the clinical context to prevent secondary victimization.
- **Forensic Rigor:** Establishing the mandatory standards for DNA collection and reporting that ensure medical evidence is admissible and effective in a court of law.

2.2. Rape: The Consent-Based Framework

The Greek legal system has undergone a fundamental paradigm shift, moving from a "resistance-based" model to a "consent-based" model, primarily through Law 4619/2019 and the subsequent reinforcements of Law 5090/2024 and Law 5172/2025.

Legal Definition (Article 336, Penal Code - Law 4619/2019)

Under the current framework, rape is established in two primary ways:

- **Force or Threat (Para. 1):** When the perpetrator, through physical force or the threat of serious and immediate danger to life or bodily integrity, compels another person to commit or endure a sexual act.
- **Absence of Consent (Para. 4):** Crucially, Law 5090/2024 clarifies that a sexual act performed without the victim's valid consent is punishable by imprisonment (up to ten years), even in the absence of physical violence. Legally, the absence of a "yes" constitutes rape; proof of "resistance" is no longer required (Penal Code, Art. 336 - Law 4619/2019).

Marital and Partner Rape

Greek law provides no exemption for marriage or civil partnerships. Under Law 3500/2006 (as amended), sexual violence within an intimate relationship is strictly prohibited and prosecuted

ex officio (automatically). The intimate relationship is often treated as an aggravating circumstance (Law 3500/2006; Law 5090/2024).

Cyber-Sexual Violence

Law 5172/2025 (incorporating EU Directive 2024/1385) addresses digital dimensions of violence. Non-consensual sharing of intimate images (“revenge porn”) and digital harassment are classified as severe violations of sexual dignity under Article 337 of the Penal Code (Law 4619/2019).

2.3. Broad Classification of Sexual Offences

While rape is the most severe, the legal “map” includes other critical offences:

- **Insult to Sexual Dignity (Art. 337):** Criminalizes acts that violate a person’s sexual dignity through gestures, words, or digital means.
- **Abuse in Indecency (Art. 338):** Specifically addresses cases where the victim is in a state of incapacity to resist (e.g., unconsciousness, intoxication, or mental disability).

2.4. Victims’ Rights: Law 4478/2017

This legislation is the primary tool for preventing **secondary victimization** (trauma caused by the legal process itself). Key rights include:

- **Right to Information (Arts. 5-7):** Victims must be informed immediately, in a language they understand, about support services, legal aid, and case progress.
- **Access to Support (Art. 61):** Victims have the right to free, confidential specialized support before, during, and after criminal proceedings.
- **Individual Assessment (Art. 22):** Authorities must conduct a timely assessment to identify specific protection needs, such as the risk of repeat violence.
- **Avoidance of Contact (Art. 19):** Victims have the right to avoid contact with the perpetrator, including testifying via video link or using separate court entrances.

2.5. Legal Duties of Healthcare Professionals

The intersection of medical ethics and criminal law has been clarified to prioritize victim safety over professional secrecy in specific circumstances.

Mandatory Reporting (Law 5172/2025)

Law 5172/2025 (Art. 20) significantly amended Article 23 of Law 3500/2006, establishing a clear statutory reporting duty:

- **Regarding Minors:** Healthcare providers (doctors, nurses, psychologists, social workers) who find **indications** (not necessarily certainty) of domestic or sexual violence against a minor must report it immediately to the prosecuting authorities.

- **Regarding Adults:** The same duty applies when indications of domestic violence against an adult are established based on **serious objective medical findings**.
- **Precedence Over Secrecy:** The law explicitly states that this reporting obligation **applies irrespective of professional secrecy**. The waiver of confidentiality is legally protected when a “higher legal duty” exists (Law 3418/2005, Art. 13).

The “Immunity” Clause

To encourage proactive protection, Law 5090/2024 ensures that professionals who report incidents in good faith **cannot be prosecuted for breach of confidentiality** or sued for defamation, provided the report was not intentionally false.

2.6. Duties of Forensic Services (Law 5172/2025, Art. 41)

For forensic doctors, the 2025 reform mandates specific procedural rigors:

- **Mandatory DNA Collection:** In complaints regarding sexual freedom, the collection of biological material for DNA testing is **mandatory** within the immediate hours following the complaint.
- **Timely Reporting:** Forensic reports must be drafted “without culpable delay”. In *in-flagrante* (red-handed) arrests, the report must be delivered immediately to the competent authority.

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3. Guiding Principles and Code of Conduct

3.1. Purpose and Scope

This section establishes the ethical foundations and practical behavioral standards for health professionals—including emergency clinicians, GPs, nurses, midwives, mental health professionals, and forensic examiners—who provide care to women survivors of sexual violence. Sexual violence encompasses rape, sexual assault, sexual coercion, and unwanted sexual acts. This protocol governs the entire continuum of care: from first disclosure to forensic examination and long-term psychosocial referral (Henin & Black, 2021; WHO, 2020; WHO & UNODC, 2015).

3.2. Core Guiding Principles: The Foundation of “Good Care”

The transition from a purely clinical “fix-it” mindset to a holistic, survivor-centered approach is mandatory (UN Women & WHO, 2019). Clinical care for women and girls who have experienced sexual violence is a high-stakes human rights intervention.

1. Survivor-Centeredness, Autonomy, and Human Rights

- **The Principle of Belief:** Practitioners must accept the survivor’s account as the factual basis for immediate care. Believing the survivor is a clinical prerequisite that fosters a safe environment and minimizes the psychological burden of disclosure (UN Women, 2022).
- **Destigmatizing Language:** Communication must be compassionate. Professionals should use the terminology the survivor prefers and avoid “judgmental jargon” or clinical labels that may disempower the individual (EIGE, 2020; UN Women, 2022).
- **Human Rights Framework:** Care must remain consistent with the principles of **privacy** and **confidentiality**. This involves ensuring the survivor maintains full control over their personal narrative and data (UN Women, 2022; WHO, 2020).
- **Informed and Revisable Consent:** Consent is a continuous process. It must be specific, informed, and can be withdrawn or modified at any stage of the history-taking or examination (U.S. Department of Justice, 2024; WHO, 2020).

2. Trauma-Informed Care (TIC)

Every interaction must aim to minimize re-traumatization. Practitioners must recognize that “counter-intuitive” behaviors—such as memory gaps, emotional numbing, or a flat affect—are common neurobiological responses to extreme stress. According to the established standards and clinical recommendations, these signs should be interpreted as symptoms of trauma rather than indicators of a lack of credibility (Greenwald et al., 2023; Henin & Black, 2021; Rape Crisis England & Wales, 2024).

3. Safety and “Do No Harm”

The professional's primary duty is to promote the survivor's safety and prevent "secondary victimization" caused by insensitive or inadequate institutional responses. The quality of initial care in the emergency setting is a critical determinant of long-term psychological recovery (Henin & Black, 2021; UN Women, 2022; WHO, 2020).

4. Non-Discrimination and Inclusion of Women and Girls

Care must be provided equitably regardless of legal status, age, or ethnicity.

- **Inclusion of Girls (Minors):** Protocols must explicitly address the developmental needs of girls, requiring specialized age-appropriate communication and strict child safeguarding adherence (UNICEF, 2024; UN Women, 2022).
- **Cultural Humility:** Addressing language barriers and sensitivities for survivors from marginalized or conflict-affected communities without resorting to stereotypes (EIGE, 2024).

5. Clinical Timeliness

Sexual violence is a medical emergency. Access to Emergency Contraception (EC) and HIV PEP must be facilitated as soon as possible, ideally within a 72-hour window, to ensure maximum efficacy (BASHH, 2022; WHO, 2021;).

3.3. Professional Code of Conduct: The "LIVES" Framework

The World Health Organization (2021) identifies five essential tasks (the **LIVES** model) that serve as the behavioral baseline for all providers:

- **Listen:** Listen closely, with empathy, and without judgment.
- **Inquire:** Assess needs and concerns without "interrogating".
- **Validate:** Show the survivor you believe her and emphasize it was not her fault.
- **Enhance Safety:** Discuss a plan to protect her from further harm.
- **Support:** Connect her to medical and social services via "warm handovers".

Conduct Standards: Do's and Don'ts

Category	DO	DO NOT
Dignity	Use non-judgmental language; communicate belief in the survivor's rights (WHO, 2021).	Express disbelief, minimize the event, or imply the survivor is responsible.
Consent	Obtain explicit consent before opening a "rape kit" (SAFETA, 2021).	Proceed based on "implied consent" or institutional convenience.
Communication	Explain each step; allow the survivor to pause or stop (Scottish Government, 2022, April 1).	Press for chronological details; clinical care is not cross-examination.
Privacy	Ensure private settings; limit staff presence to essentials (Henin & Black, 2021; HIS, 2024; WHO, 2024).	Share details with police or third parties without consent.

3.4. Forensic and Medico-Legal Responsibilities

When a survivor chooses to engage with the justice system, the professional acts as a bridge to forensic integrity.

- **Evidence Preservation:** Even in pre-hospital settings, workers must document injuries and preserve evidence without compromising life-saving care (IAFN, 2022).
- **Standardized Documentation:** Use factual, non-speculative language and standardized indicators (EIGE, 2023; HIS, 2020).
- **Confidentiality vs. Mandatory Reporting:** Professionals must transparently explain the limits of confidentiality early on. The primary duty remains the survivor's safety (British Red Cross & ICRC, 2020).

3.5. Institutional Standards and Workforce Wellbeing

- **Integrated Pathways:** Services must utilize established, multi-agency referral pathways to NGOs and specialized **Sexual Assault Response Coordination Services (SARCS)** to ensure a seamless transition from acute clinical care to long-term recovery support (HIS, 2024; Scottish Government, 2022, April 1).

- **Workforce Support:** Institutions must formally recognize the high risk of burnout and vicarious trauma inherent in gender-based violence care (Henin & Black, 2021; WHO, 2021). Fostering a supportive organizational culture that prioritizes the health, resilience, and safety of the workforce is not only an ethical mandate but a fundamental prerequisite for maintaining patient safety and high-quality care (WHO, 2024).
- **Accountability and Patient Safety:** Services must implement robust quality indicators to monitor timeliness and survivor feedback, ensuring that performance data drive continuous improvements in care safety and effectiveness (HIS, 2020; WHO, 2024).

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4. Health Facilities Minimum Standards

4.1. Purpose and Scope

These standards define the baseline requirements for infrastructure, staffing, supplies, and governance that any health facility—from hospital Emergency Departments (EDs) to specialized **Sexual Assault Response Coordination Services (SARCS)**—must meet to provide safe, ethical, and effective care (HIS, 2024). Facility readiness is not optional; it is a fundamental component of the right to health and a prerequisite for patient safety (WHO, 2020; WHO, 2024).

4.2. Infrastructure and the Physical Environment

The physical environment is the first signal to a survivor that they are in a safe, professional space (WHO, 2018). Facilities must transition away from “business as usual” or institutional layouts to trauma-sensitive designs that prioritize dignity, privacy, and safety (HIS, 2024; WHO, 2020). These environments must be dedicated, safe, and effectively managed to ensure they are suitable for children, young people, and adults alike (HIS, 2024).

- **Privacy and Confidentiality:** Facilities must provide a dedicated, private examination room that is soundproofed and visually shielded (NHS England, 2023). The environment must ensure that the patient cannot be seen or heard from the outside during counseling or clinical services (WHO, 2018). Access to these rooms and the records within them must be strictly controlled to prevent unauthorized exposure (WHO, 2021). Privacy must be maintained from the initial triage/intake process through to the clinical exam, where survivors should have a private space to undress and dress (WHO, 2018).
- **Security and Discreet Access:** Entry and exit points should be discreet to protect the survivor’s identity, with signage that avoids stigmatizing language, such as using “Wellness Center” instead of “Rape Center” (UN Women et al., 2015; WHO, 2018). Ideally, 24-hour security presence should be available, with staff specifically trained in gender-sensitive approaches (UN Women et al., 2015).
- **Sanitary Facilities:** Dedicated, private bathroom and shower facilities must be available for the survivor’s exclusive use immediately following a forensic examination (HIS, 2024). These toilets or latrines must be lockable from the inside and have access to clean water (WHO, 2018).
- **Forensic Suitability:** Technical specifications for examination rooms include high-intensity lighting and secure, locked storage for evidence to maintain a rigorous chain of custody (WHO & UNODC, 2015). This includes lockable cabinets or rooms for secure storage of patient files and forensic evidence (WHO, 2018).
- **Low-Resource Adaptations:** In humanitarian or resource-constrained settings, facilities must implement realistic privacy safeguards, such as screens and controlled patient flow, ensuring that protection is never sacrificed due to lack of permanent infrastructure (IAWG, 2018; WHO, 2018).

4.3. Essential Medical Supplies and Clinical Readiness

A facility's clinical readiness is defined by its ability to provide the Minimum Initial Service Package (MISP) and the continuous, 24/7 availability of essential medicines and equipment. The lack of immediate access to these supplies constitutes a failure in the standard of care and a barrier to the survivor's right to health (WHO, 2017; WHO, 2018).

- **Emergency Contraception (EC):** Oral emergency contraception must be stocked and provided as soon as possible, ideally within 72 to 120 hours of the assault (BASHH, 2022; WHO, 2018; WHO, 2023). In cases where oral EC is unavailable, trained providers may offer the insertion of a copper-bearing intrauterine device (IUCD) if the survivor is seeking ongoing pregnancy prevention (WHO, 2018).
- **Post-Exposure Prophylaxis (PEP):** Starter kits for HIV prevention must be available 24/7 (WHO, 2018). Due to time-dependent efficacy, facilities must have a clear pathway for administration within the 72-hour window (WHO, 2018; WHO, 2021).
- **STI Prophylaxis and Presumptive Treatment:** Routine presumptive treatment for sexually transmitted infections (including chlamydia, gonorrhea, syphilis, and trichomoniasis) must be available on-site (BASHH, 2022; WHO, 2017). Facilities must also stock Tetanus vaccines for administration if the survivor's vaccination status is uncertain (WHO, 2018).
- **Priority Medical Devices and Infrastructure:** Facilities must be equipped with high-priority medical devices for reproductive health, including high-intensity angle lamps for pelvic examinations, speculums of various sizes for adults and adolescents, and basic resuscitation equipment (WHO, 2016; WHO, 2018).
- **Forensic Evidence Kits and Medico-Legal Documentation:** Standardized kits for the collection of DNA, clothing, and toxicology samples must be kept in a secure area (FFLM, 2020). Both forensic kits and medico-legal forms must be stored in lockable cabinets or rooms to ensure a rigorous chain of custody and protect patient confidentiality (WHO & UNODC, 2015; WHO, 2018).

4.4. Human Resources and Training

A facility is only as effective as its workforce. Staffing standards ensure that survivors—both women and girls—interact with specialized, competent personnel who provide care within a framework of professional and ethical accountability.

- **Specialized Training (The LIVES Model):** All frontline healthcare providers must be trained in the WHO “LIVES” psychological first aid model (**Listen, Inquire, Validate, Enhance safety, Support**) to provide essential first-line support (WHO, 2018; WHO, 2021). Training curricula must prioritize trauma-informed care, the principle of belief, and the clinical requirements for obtaining informed, revisable consent (Rape Crisis England & Wales, 2024; WHO, 2021).
- **Forensic and Clinical Expertise:** Facilities should ensure access to Sexual Assault Nurse Examiners (SANE) or medical practitioners with specific forensic training. These specialists ensure that clinical care and evidence collection are conducted methodically,

reducing the risk of secondary victimization (IAFN, 2022; Rape Crisis England & Wales, 2024).

- **Gender Preference and Equity:** Whenever possible, survivors must be offered a choice regarding the gender of their healthcare provider and forensic examiner. Services must be inclusive and accessible to all, regardless of legal status, disability, or language barriers, ensuring a culturally humble and equitable response (EIGE, 2024; Rape Crisis England & Wales, 2024).

4.5. Administrative, Operational, and Governance Standards

- **Standard Operating Procedures (SOPs):** Every facility must maintain written, localized SOPs defining triage, clinical assessment, and referral pathways (GBV AoR, 2023).
- **Standardized Documentation:** The use of factual, standardized intake forms and medico-legal reports is required to ensure data quality and legal admissibility (EIGE, 2023).
- **Coordinated Referral Pathways:** Facilities must maintain an updated referral network. "Warm handovers" are the gold standard (UN Women et al., 2015).
- **Quality Monitoring:** Facilities should conduct regular audits using defined indicators (e.g., timeliness of PEP) to ensure they meet standards (HIS, 2020).

4.6. Facility Self-Assessment Checklist

Category	Requirement	Source
Governance	Are there written SOPs for triage and referral?	WHO, 2020
Environment	Is there a private, soundproofed room for examinations?	NHS England, 2023
Supplies	Is EC and HIV-PEP available 24/7 on-site?	WHO, 2023
Workforce	Are staff trained in trauma-informed care and LIVES?	WHO, 2021
Forensics	Is there a secure, locked storage for evidence?	WHO & UNODC, 2015
Coordination	Is there a formal, updated referral directory?	UN Women, 2023

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PHASE 2: THE ACUTE ENCOUNTER

5. Consent and Information Sharing

5.1. Purpose and Scope

This section establishes the standards for obtaining valid, trauma-informed consent and managing the delicate balance of confidentiality and information sharing. The overarching goal is to restore the power and control stripped away during an assault, ensuring the survivor remains the "pilot" of her own care (HSE, 2023; WHO, 2021).

5.2. The Principle of Iterative Informed Consent

In the context of sexual violence, consent is not a singular event or a blanket signature; it is a continuous, granular process that must be reaffirmed at every stage of the clinical encounter.

- **Valid Consent Criteria:** To be ethically and legally robust, consent must be informed (understanding benefits/risks), voluntary (free from coercion), specific (to each procedure), and ongoing (revocable at any time) (U.S. Department of Justice, 2024; WHO, 2021).
- **Granularity:** Survivors have the right to accept specific elements of care while refusing others. For example, a survivor may consent to STI prophylaxis but refuse a forensic examination or photography. This refusal must be documented without judgment and must not preclude access to other medical services (HSE, 2023; WHO, 2020).
- **Capacity Assessment:** Practitioners must assess the survivor's capacity to consent, accounting for shock, dissociation, or substance influence. If capacity is acutely impaired, life-saving medical care takes precedence over forensic collection until the survivor can provide informed authorization (BASHH, 2022; NHS Scotland, 2024).

5.3. Confidentiality and the “Duty to Warn”

While confidentiality is the cornerstone of the therapeutic relationship, it is rarely absolute. Navigating its limits requires transparency and professional courage.

The Pre-Disclosure Caveat

Before a survivor shares the details of an assault, the professional must provide an “interview caveat”. This involves explaining the legal mandates (e.g., mandatory reporting for serious crimes or child safeguarding) before the survivor discloses information that might trigger these requirements (GMC, 2018; Dheensa & Feder, 2022).

Mandatory Reporting vs. Survivor Safety

In jurisdictions where reporting is legally mandated, the professional’s primary mandate remains the survivor's safety. If reporting to authorities poses an immediate risk of further violence (e.g., in domestic abuse or conflict settings), the professional must prioritize protection over legal compliance, applying a proportionality-based decision framework (British Red Cross & ICRC, 2020; WHO, 2021).

5.4. Data Management and Multi-Agency Coordination

Information sharing with external agencies (Police, NGOs, Social Services) must adhere to the principle of “Data Minimization”—sharing only the minimum necessary information to ensure safety.

Consent vs. Confidentiality: A Comparison

Feature	Consent	Confidentiality
Definition	Permission for a specific action/procedure.	The duty to protect personal data.
Control	Resides entirely with the survivor.	Subject to defined legal/ethical exceptions.
Requirement	Needed for every physical exam or swab.	Assumed as default, except in “Duty to Warn” cases.

Operational Standards

- **Need-to-Know Sharing:** In multi-agency forums, disclosures should be specific and limited to what is essential for risk management. Broad, non-specific sharing is a breach of ethics (Dheensa & Feder, 2022).
- **Digital Security:** GBV-related medical records must be stored in high-security, encrypted systems with restricted, role-based access to prevent data breaches (FRA, 2024; EIGE, n.d.).

5.5. Forensic and Documentation Specifics

- **Self-Referral Options:** Survivors must be informed that they can often choose a “Self-Referral” forensic exam, where evidence is collected and stored anonymously without immediate police involvement (NHS Scotland, 2024; Scottish Government, 2022, April 1).
- **Objective Documentation:** Documentation must be factual and objective, avoiding speculative or judgmental descriptors like the patient “claimed” or “alleged”. Record survivor preferences and consent discussions contemporaneously (Government of Kerala, 2019; NHS England, 2023).

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6. Risk Assessment and Addressing Women Survivors' Needs

6.1. Purpose and Scope

This section provides an evidence-informed protocol for health professionals to conduct multi-dimensional risk assessments and respond to the diverse needs of women survivors. High-quality care is grounded in a survivor-centred, trauma-informed, and rights-based approach (WHO, 2021). Professionals must prioritize dignity, choice, and informed consent, ensuring that care is never conditional upon the survivor's legal status or their decision to report to the police (Scottish Government, 2022, April 1; U.S. Department of Justice, 2024).

6.2. First Contact: Immediate Priorities and Rapid Triage

The first minutes of a clinical encounter set the trajectory for recovery. Variability in emergency department readiness can lead to loss to follow-up; therefore, structured, person-centered pathways are mandatory to ensure clinical continuity and safety (Chalmers et al., 2023; HIS, 2024; WHO, 2024).

1. **Create Immediate Safety:** Move the survivor to a private, trauma-sensitive room away from public waiting areas immediately upon arrival (HIS, 2024). Offer the presence of an advocate or support person to enhance the survivor's sense of safety and control (HIS, 2024; RCN, 2020;).
2. **Stabilise Urgent Medical Needs:** Perform a rapid triage to assess airway, breathing, and circulation (ABCs). Identify and prioritize life-threatening injuries, severe bleeding, or suspected strangulation, ensuring that clinical interventions are delivered without delay (HIS, 2024; WHO, 2020).
3. **Obtain Continuous Consent:** Explain all care options (medical, forensic, and referral) clearly and in an accessible format. Consent must not be viewed as a one-time event but must be revisited and confirmed before every procedure or examination step (HIS, 2024; HSE, 2023; IAFN, 2022).

6.3. Multi-Dimensional Risk Assessment: The Four Domains

Risk assessment is a dynamic process that evaluates the intersection of clinical vulnerability and systemic barriers (EIGE, 2019).

Domain A: Physical and Clinical Risk

- **Acute Injuries:** Document hidden injuries and neurological symptoms.

- **Reproductive Risk:** Assess for unwanted pregnancy and STI/HIV exposure. The efficacy of Emergency Contraception (EC) and Post-Exposure Prophylaxis (PEP) is highly time-dependent (BASHH, 2022; WHO, 2020).

Domain B: Psychological and Emotional Risk

- **Acute Reactions:** Screen for signs of severe distress, such as feeling overwhelmed, confused, or emotionally numb (dissociation), as well as intense fear, panic, and shame (WHO, 2013; WHO, 2021).
- **Lethality of Intent:** Identify individuals who may be a danger to themselves or others, specifically screening for acute suicidal ideation or self-harm (WHO, 2013). Evidence indicates that PTSD symptoms are most elevated in the year following an assault (Dworkin et al., 2023; WHO, 2021).

Domain C: Safety and Safeguarding Risk

- **Perpetrator Dynamics:** If the perpetrator is an intimate partner, assess for high-risk markers: access to weapons, history of strangulation, or recent separation (EIGE, 2019; U.S. Department of Justice, 2024).
- **Immediate Logistics:** Ensure safe transport and safe accommodation for the survivor (UN Women, 2023).

Domain D: Systemic Support Needs and Barriers

- **Access Barriers:** Identify needs for interpreters, cultural mediation, or disability access.
- **Displaced Populations:** Address specific barriers for women fleeing war, such as lack of documentation or fear of authorities (EIGE, 2024; FRA, 2024).

6.4. Addressing Emotional and Psychological Needs

Emotional care is a pillar of clinical safety. The primary objective is to facilitate the survivor's transition from acute crisis to psychological stabilization through evidence-based, trauma-informed support.

- **The LIVES Model:** Health professionals must utilize the WHO-recommended model: **Listen, Inquire, Validate, Enhance safety, and Support**. Validation—specifically the act of explicitly believing the survivor and acknowledging the gravity of the assault—is the single most effective clinical intervention to mitigate long-term psychological damage and foster positive mental health outcomes (Thoresen et al., 2025; WHO, 2021).
- **Trauma-Informed Presence:** Practitioners must avoid rigid, checklist-driven interactions that can mimic the powerlessness of the assault. Survivors consistently report that an “unhurried presence”, clear communication, and a clinical environment that restores their sense of control are fundamental to building trust and preventing secondary victimization (Peeren et al., 2025; WHO, 2021).

6.5. Safety Planning and Multi-Sectoral Coordination

A health professional's role continues until a viable path forward is established.

1. **Personalized Safety Planning:** Every survivor should leave with a plan that includes safe destinations, secure communication methods, and emergency NGO contacts (GBV AoR, 2023; Scottish Government, 2022, April 1).
2. **Referral Pathways (The “Warm Handover”):** Passive referrals often fail. Facilitate direct connections to legal aid, housing, and specialized counseling (UNFPA, 2019; NHS England, 2023).
3. **Forensic Choice:** If a survivor chooses a forensic exam, ensure it is performed by trained staff following strict chain-of-custody and documentation procedures (IAFN, 2022; WHO, 2015).

6.6. Quality Assurance and Crisis Contexts

- **Service Standards:** Facilities should implement and adhere to updated national and international standards, such as those for **Sexual Assault Response Coordination Services (Scotland)**, to systematically audit technical accuracy and clinical safety (HIS, 2024).
- **Survivor Experience and Feedback:** A primary objective of quality assurance is the continuous monitoring of the survivor experience. Facilities must establish robust mechanisms to collect and analyze feedback to ensure care remains person-centered and trauma-informed (HIS, 2024).
- **Multidimensional Quality Monitoring:** Health systems should utilize multidimensional analysis and measurable indicators to track service quality, timeliness, and patient safety, ensuring that standards are maintained even during systemic stress (HIS, 2024; WHO, 2024).
- **Humanitarian Settings:** In conflict zones or crisis contexts, practitioners must prioritize the Minimum Initial Service Package (MISP), focusing on the maintenance of absolute confidentiality and the mapping of feasible, resilient referral structures (ICRC, 2019; UN/OCHA, 2020; WHO, 2024).

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7. Interviewing survivors

7.1. Purpose and Scope

This section defines the standards for clinical communication—including disclosure conversations, medical/forensic history-taking, and psychosocial enquiry—with women survivors of sexual violence. The objective is to conduct interviews that are survivor-centred and forensically sound without transforming the healthcare setting into an investigative interrogation (WHO, 2020; U.S. Department of Justice, 2023).

7.2. The Foundations of Trauma-Informed Communication

The “physics” of a disclosure conversation must account for both the physical environment and the survivor’s biological state.

- **The Neurobiology of Trauma:** Health professionals must recognize that extreme stress causes the brain to prioritize survival over linear encoding. This results in “fragmented” memories. Inconsistencies are a physiological symptom of a “freeze” or “dissociate” response (Campbell, 2012, December 1; RCN, 2020).
- **The Physical and Digital Environment:** Interviews must occur in a private, quiet space where the survivor feels in control of exits (WHO, 2013). For remote consultations, clinicians must verify a secure location (UN Women, 2020; WHO, 2020).
- **Leveling the Power Imbalance:** Clinicians should ask permission for every micro-action and offer choices regarding the pace (WHO, 2021).

7.3. Core Communication Techniques: The LIVES Model

First-line support is a primary predictor of recovery. The WHO (2021) reaffirms the “LIVES” framework (Listen, Inquire, Validate, Enhance Safety, Support) as the gold standard for clinical care.

7.4. The Stepwise Interviewing Process

- **Step 1 (Opening):** Use safe opening scripts: “I’m sorry this has happened. You control what you share” (IAFN, 2022; WHO, 2020).
- **Step 2 (Triage):** Check for acute pain or dissociation before seeking details (Scottish Government, 2022, April 1; UNFPA, 2019).
- **Step 3 (Trauma-Informed Questioning):** Start with open-ended prompts: “Tell me what you are able to remember” (IAFN, 2022). Use sensory prompts (smells, sounds) to assist retrieval (OHCHR, 2022; UNODC et al., 2020). Never ask “Why” questions (RCN, 2020).

7.5. Documentation and Ethics

- **Objective Recording:** Distinguish between verbatim quotes and clinician observations (HSE, 2023; U.S. Department of Justice, 2023).
- **Interagency Coordination:** Coordinate with police (with consent) to reduce the harm of “repeated retelling” (Stahlmann et al., 2021, July 30).

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8. Examination and Healthcare

8.1. Purpose and Scope

This section provides a structured, evidence-informed framework for clinicians and health professionals examining and caring for women and adolescent girls who have experienced sexual violence. The modern health-sector response has shifted from a segmented medical-legal approach to a **Biopsychosocial Model**. This model recognizes that physical injuries, psychological trauma, and social context (e.g., migration status, ethnicity, or disability) are inextricably linked and must be addressed simultaneously (EIGE, 2024; WHO, 2021).

8.2. Core Guiding Principles

Every interaction within the health system must be grounded in trauma-informed, survivor-centred care. This is not merely ‘soft skill’ territory; it is a clinical necessity that dictates the success of long-term recovery (UN Women et al., 2015; WHO, 2013).

- **Safety First:** Prioritize immediate medical stabilization and safeguarding needs over all other tasks (WHO, 2020).
- **Continuous Informed Consent:** Consent is specific and reversible; it must be obtained at every step, including history-taking, physical examination, photography, evidence collection, and information sharing (HSE, 2023; U.S. Department of Justice, 2024).
- **Choice and Autonomy:** Survivors must remain the “pilot” of the process. Offer clear options: medical-only care, forensic examination (with or without police involvement), or referral to specialist services (Scottish Government, 2022, April 1).
- **The LIVES Framework:** This WHO gold standard (2021) provides the behavioral baseline for all providers: **L**isten, **I**nquire about needs, **V**alidate (explicitly stating “I believe you”), **E**nhance safety, and **S**upport.

8.3. Immediate Response: Triage and First Contact

The first clinical encounter strongly shapes the survivor's willingness to engage with follow-up care. Facilities must be prepared to move survivors out of public waiting areas immediately to prevent secondary victimization (Chalmers et al., 2023).

Time-Sensitive Care Checklist:

Timeframe	Clinical Priority	Notes
Immediately	Stabilize; treat life-threatening injuries; assess immediate safety/mental state.	Do not delay urgent care for forensic tasks (WHO, 2020).
Same Day	Pregnancy prevention (EC) and HIV Post-Exposure Prophylaxis (PEP) risk assessment.	EC efficacy is time-dependent (BASHH, 2022).
As soon as feasible	Forensic clinical examination (if chosen); standardized documentation.	Ensure “reversible consent” is maintained (HSE, 2023).
Follow-up	Review injuries; repeat testing; proactive psychosocial outreach.	Coordination reduces loss to follow-up (WHO, 2020).

8.4. Physical Healthcare and Clinical Assessment

Assessment must balance thoroughness with the need to minimize distress.

History-Taking and Physical Exam:

- **Purpose-Limited History:** Collect only what is needed for immediate clinical decisions first, including medications, pregnancy status, and assault details relevant to contact sites (HSE, 2023; WHO, 2020).
- **Acute Injury Care:** Conduct a head-to-toe assessment for visible and “invisible” injuries. **Non-fatal strangulation** must be documented with high priority, as it is a critical indicator of future lethality (U.S. Department of Justice, 2024; Government of Kerala, 2019).

Reproductive and Sexual Health (SRH):

- **Emergency Contraception (EC):** Provide immediate access within 72–120 hours.
- **HIV PEP:** Administer within 72 hours where indicated.
- **STI Prophylaxis:** Offer presumptive treatment per national protocols (BASHH, 2022).

8.5. Emotional and Psychological Care

Emotional support is the environment in which medical care happens. Early, supportive social reactions from health professionals significantly reduce the likelihood of long-term PTSD (Dworkin et al., 2023).

- **Validate and Normalise:** Communicate that fear, numbness, or anger are common, “normal” responses to an abnormal event (RCN, 2020).

- **The Forensic Experience:** Acknowledge that the forensic exam can feel intrusive. Mitigate this by offering “stop” signals and explaining every tool before it is used (Berger et al., 2023).

8.6. Multi-Agency Coordination and Standards

To ensure a seamless journey for the survivor, health systems must implement robust collaborative leadership and referral pathways that bridge the gap between initial disclosure and long-term recovery (HIS, 2024).

- **Service Pathways:** Establish clear, coordinated referral routes to **Sexual Assault Response Coordination Services (SARCS)** or specialized NGOs. These pathways must support adults in accessing healthcare and support at any time following disclosure, including self-referral options within the first seven days of an incident (HIS, 2024). “Warm handovers”—where a practitioner directly connects the survivor to the next service provider—are the gold standard for clinical continuity and are preferred over simply providing contact information (NHS England, 2023; HIS, 2024).
- **Quality Assurance:** NHS boards and health facilities must use measurable indicators to monitor access, timeliness, and the survivor’s experience of care (HIS, 2024). The systematic use of multidimensional data is essential for “taking the pulse” of care quality and patient safety across the health system (WHO, 2024). Facilities should undergo regular audits and self-assessments to maintain technical and ethical competence and ensure compliance with national and international safety standards (HIS, 2024; WHO, 2024).
- **Inclusive Access and Cultural Sensitivity:** Care must be tailored for displaced women, marginalized groups, and those with additional support needs to ensure that language barriers, legal status, or disabilities do not prevent access to the “Essential Services Package” (EIGE, 2024; HIS, 2024; UNFPA, 2019). Services should prioritize shared decision-making and ensure that all information is provided in accessible, person-centered formats (HIS, 2024).

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9. Medical Assessment and Collection of Physical Evidence: The Sexual Assault Evidence Kit (SAEK)

9.1. Purpose and Ethical Foundations

This protocol establishes a structured, evidence-informed framework for the medical assessment of women survivors and the collection of physical evidence. All interventions are grounded in three core pillars:

1. **Survivor-Centred “Do No Harm”:** Responses must reduce harm and avoid “secondary victimisation”. The clinical environment must be private, paced, and respectful (WHO, 2020; NHS England, 2023).
2. **Continuous Informed Consent:** Consent is not a one-time signature. It must be obtained for each discrete component—history, physical exam, photography, and specimen collection. It is specific and reversible; the survivor may stop the exam or refuse any individual part at any time (HSE, 2023; U.S. Department of Justice, 2023).
3. **The “Pilot” Principle:** The survivor remains the “pilot” of the procedure. Literature confirms that maintaining autonomy during the exam significantly improves the survivor's experience and reduces long-term trauma (Stewart et al., 2025; WHO, 2021).

9.2. Clinical Workflow: Immediate Medical Assessment

Clinical stabilization always supersedes evidence collection. The safety and stabilization of the survivor are the paramount clinical priorities.

Triage and Safety

- **Emergency Stabilization:** Immediate assessment and management of life-threatening injuries (e.g., severe bleeding, airway compromise, severe pain, or altered consciousness) is the first priority in the clinical encounter (WHO, 2020).
- **Safety Planning:** Assess immediate risks, including the ongoing threat from a perpetrator, and initiate standardized safeguarding procedures to protect the survivor (HIS, 2024). Safety planning must be integrated into the care pathway to ensure clinical and psychological safety from the point of first contact (HIS, 2024).
- **Patient Safety Governance:** Facilities must adhere to multidimensional safety frameworks to minimize clinical risks and ensure that safeguarding measures are robust and consistently applied (WHO, 2024).

Trauma-Informed History-Taking

History should be limited to what is clinically and forensically necessary. Key domains include:

- **Assault Timing:** Essential for evidence windows.
- **Clinical Risks:** Pregnancy and STI/HIV exposure.
- **Forensic Relevance:** Contact sites, condom use, and post-event actions (bathing/urination) (HSE, 2023; U.S. Department of Justice, 2023).

Testing and Prophylactic Treatment

- **Emergency Contraception (EC):** Administered as soon as possible, ideally within 72–120 hours.
- **Post-Exposure Prophylaxis (PEP):** HIV prevention must be initiated within 72 hours (BASHH, 2022; WHO, 2021).
- **STI Prophylaxis:** Presumptive treatment for chlamydia, gonorrhea, and syphilis should be provided on-site (BASHH, 2022).

9.3. Forensic Evidence Collection: The “SAEK”

The SAEK is an option, not an obligation (NHS England, 2023). To be admissible in court, the **Chain of Custody** must be flawless (UNODC, 2011; SAFETa, 2021).

Step-by-Step SAEK Proces

Step	Action	Technical Requirement
1. Preparation	Private, controlled room.	Use PPE; change gloves between every sample (SAFETA, 2021).
2. Documentation	Document injuries with body maps.	Use Alternate Light Sources (ALS) to detect fluids (U.S. Department of Justice, 2023).
3. Collection	Swabs, fibers, toxicology.	Collect only what is relevant; avoid unnecessary invasion (HSE, 2023).
4. Labelling	Label each specimen immediately.	Complete chain-of-custody documentation (FFLM, 2024).
5. Storage	Securely store in a locked area.	Follow refrigeration and handover protocols (NHS England, 2023).

9.4. Specialized Situations

- **Early Evidence Collection:** If a full exam is delayed, “early evidence” (urine or outer-body swabs) should be collected to prevent DNA loss (HSE, 2023; NSW Health, 2013).
- **Toxicology:** In suspected drug-facilitated sexual assault (DFSA), samples must be collected within specific time windows (U.S. Department of Justice, 2023; SAFETA, 2021).
- **Pre-Hospital Care:** EMS providers must prioritize privacy and instruct survivors not to wash or change clothes until the exam (IAFN, 2022; RCN, 2020).

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10. Documentation and Reporting

10.1. Purpose and Scope

This section provides a standardized framework for health professionals to document and report sexual violence in a manner that is clinically effective, legally defensible, and trauma-informed (WHO, 2020). It encompasses the entire lifecycle of a medical-legal record: from initial intake and forensic examination to secure data retention and multi-agency reporting (HSE, 2023). The primary objective is to uphold the survivor's rights and safety while ensuring that clinical documentation can support justice processes without compromising the quality of care (WHO, 2020; HSE, 2023).

10.2. Core Principles: Survivor-Centered and Neutral

Effective documentation is guided by three pillars:

- **Clinical Priority:** Documentation supports diagnosis and treatment first (WHO, 2020). Forensic evidence collection is secondary but must be performed with high technical precision to avoid “re-traumatization” through repeated examinations (HSE, 2023).
- **Objective Neutrality:** Practitioners must use factual, observable language (WHO, 2021). Biased or skeptical terms such as “allegedly” or “claims” must be avoided (U.S. Department of Justice, 2024). Instead, use the survivor's exact words in quotation marks to describe the assault, ensuring the narrative remains survivor-led (WHO, 2021; U.S. Department of Justice, 2024).
- **Professionalism in Descriptions:** Avoid subjective labels regarding the survivor's emotional state unless it is directly relevant to clinical care (FFLM, 2024). Focus strictly on “clinical facts” (FFLM, 2024).

10.3. The Documentation Process

Intake and Administrative Integrity

- **Detailed Record Keeping:** Clinical records must include the survivor's full name, exact date and time of attendance, the precise location of the examination, and the names of all clinicians and staff involved in the encounter (HIS, 2024; HSE, 2023;).
- **Documentation of Third Parties:** It is critical to explicitly document the presence of all third parties, including professional interpreters, advocates, or support persons (HIS, 2024). This is necessary because their presence can impact the survivor's privacy and carries significant weight in subsequent legal proceedings or testimony (HIS, 2024).

- **Data and Legal Integrity:** Consistent documentation and standardized data collection are required to minimize variation, prevent errors, and ensure a high-quality national approach to forensic reporting (HIS, 2024). Adhering to these governance functions is a core component of maintaining patient safety and system accountability (WHO, 2024).

Capturing the Narrative

Record the essentials using the survivor’s own words without forcing a chronological narrative (WHO, 2020). This includes the approximate timeframe, immediate symptoms (bleeding, pain, or strangulation), and factors affecting clinical decisions, such as potential drug-facilitated assault (U.S. Department of Justice, 2024). If a survivor chooses not to describe the event, document this choice and proceed with the clinical care they accept (Scottish Government, 2022, April 1).

Informed Consent

Document the process of explaining options between medical care and forensic exams (HSE, 2023). Record explicitly what was accepted or declined, any capacity issues that required a deferral, and specific consent for each component, such as toxicology or photography (Government of Kerala, 2019; HSE, 2023).

10.4. Clinical Findings and Forensic Evidence

Injury Mapping and Photography

- **Anatomical Precision:** Use standardized body maps to document every mark, bruise, or laceration, including measurements and appearance (WHO, 2020; HSE, 2023).
- **Advanced Technology:** Use Alternate Light Source (ALS) technology to identify "invisible" trauma, such as sub-surface bruising (Scafide et al., 2023).
- **Photographic Protocol:** Every forensic photograph must include a scale for size reference and an "orienting shot" to show the injury's location on the body (NHS England, 2023).

Chain of Custody

Any physical evidence or documented notes must have a logged “paper trail” (UNODC, 2011). Document every item collected, sealed, and transferred; a break in this chain can render evidence inadmissible (Forensic Science Regulator, 2023).

10.5. Reporting and Information Sharing

Practitioners must explain the limits of confidentiality before disclosure (GMC, 2018). While survivor choice is the default, a “duty to disclose” may supersede confidentiality in cases of high risk to children or immediate lethal danger (GMC, 2018; COPFS, 2024).

- **Minimum Necessary Disclosure:** Share only the information required for safety or justice, protecting the survivor's wider medical history (OHCHR, 2022).
- **Humanitarian Contexts:** In conflict settings, documentation must prevent data from being used to target survivors or their families (GBV AoR, 2023).

10.6. Records Management and Governance

Sexual assault records—including Electronic Sexual Assault Records (ESARs)—should be stored in encrypted systems with restricted access (Cottler-Casanova et al., 2025). Retention periods for these records are typically longer than standard medical files to allow for late-reporting survivors to seek justice (Digital Health & Care Scotland, 2024).

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PHASE 3: AFTERCARE

11. Follow-up Care

11.1. Purpose and Scope

Follow-up care is a critical clinical intervention designed to mitigate preventable medical, psychological, and social harms. It should be survivor-centered, trauma-informed, and choice-based, ensuring that access to healthcare is never conditional on police reporting or the depth of disclosure (WHO, 2020; UNFPA, 2019).

Follow-up care pursues three integrated objectives:

1. **Medical Continuity:** Managing infection window periods, reproductive health, and injury recovery.
2. **Psychological Recovery:** Active screening for PTSD and early identification of mental health trajectories (O'Doherty et al., 2023).
3. **Pathway Continuity:** Facilitating “warm handovers” to specialist advocacy and support services.

11.2. Pre-Discharge: The Foundation of Follow-up

The success of follow-up care is largely determined during the initial contact and the effectiveness of the discharge process. Before a survivor leaves the facility, a whole-system approach must be implemented to ensure sustainable and high-quality continuity of care (WHO, 2024).

- **Written Follow-up Plan:** Provide clear, simple, and accessible instructions regarding emotional and physical recovery, “danger symptoms” requiring urgent medical attention, and support for medication adherence (HIS, 2024). This information should be tailored to the individual’s needs (HIS, 2024; O'Doherty et al., 2023).
- **Safe Contact Protocols:** Explicitly confirm whether it is safe to contact the survivor via phone, SMS, or email. Record any specific safety constraints, such as shared digital devices or living arrangements with a perpetrator, to prevent unintended harm (UN Women, 2022; HIS, 2024).
- **The “Warm Handover”:** Rather than merely providing a leaflet, clinicians should directly facilitate a connection to specialized NGOs or long-term support services. This coordinated transition is a core requirement of SARCS to prevent survivors from “falling through the

cracks” of the health and social care system (NHS England, 2023; Scottish Government, 2022, April 1; HIS, 2024).

11.3. Medical Follow-up Track

Medical monitoring must account for the biological “window periods” of infections.

- **HIV Post-Exposure Prophylaxis (PEP):** If prescribed, the 28-day course of PEP is the most immediate task. Clinicians must monitor for side effects, as completion rates are historically low (BHIVA, 2021; WHO, 2021).
- **STI Screening and Re-testing:** Initial negative results may be “false negatives”. Follow-up for syphilis and other STIs is required at 6 weeks and 3 months (BASHH, 2022; CDC, 2021).
- **Vaccination Series:** Ensure completion of Hepatitis B and HPV vaccine doses started during the initial visit (HSE, 2023).
- **Managing Delayed Physical Symptoms:** Practitioners should provide low-barrier access for reassessment of delayed pain or genitourinary symptoms (WHO, 2020).

11.4. Psychosocial and Mental Health Track

The transition from acute crisis to long-term recovery is a period of high risk for chronic conditions. To mitigate these risks, health systems must adopt a whole-system approach that ensures sustainable, equitable, and evidence-based psychosocial support, bridging the gap between clinical intervention and social reintegration (WHO, 2024).

- **Evidence-Based PTSD Screening and Monitoring:** Active, systematic screening for Post-Traumatic Stress Disorder (PTSD) should occur in the months following an assault (Dworkin et al., 2023). Social reactions to disclosure—whether supportive or negative—act as primary catalysts for the development and maintenance of chronic PTSD (Ullman, 2023). Systematic review data further emphasize the necessity of structured psychosocial monitoring to prevent the escalation of symptoms (O'Doherty et al., 2023).
- **The “Do No Harm” Principle in Early Intervention:** While immediate support is vital, psychological debriefing—formalized, one-session interventions that prompt a person to recount the traumatic event—should **not** be used as a routine intervention (WHO, 2012). Instead, practitioners should offer Psychological First Aid (PFA), focusing on basic needs and safety without forcing the survivor to recount details prematurely (IASC, 2007; WHO, 2012).
- **Tiered Psychosocial Support:** Support should be structured according to the IASC intervention pyramid, ranging from the restoration of social considerations and basic services to specialized clinical care (IASC, 2007). The coordination of these tiers is a core function of **Sexual Assault Response Coordination Services (SARCS)**, ensuring a seamless journey from community-based support to trauma-focused therapies (HIS, 2024; O'Doherty et al., 2023).

- **Trauma-Focused Interventions:** Survivors presenting with persistent symptoms (e.g., after one month) should be referred for specialized care, such as Trauma-Focused CBT or EMDR (NICE, 2018). Current high-level evidence demonstrates that tailored psychosocial interventions, when delivered by trained professionals, significantly reduce PTSD and depression severity compared to standard care (O'Doherty et al., 2023; WHO, 2024).
- **Professional Posture and Iterative Consent:** Long-term follow-up requires a shift in professional posture from “examiner” to “collaborator” (IAFN, 2022; SAMHSA, 2014). Services must implement trauma-informed guidance that prioritizes the survivor's autonomy and empowerment (SAMHSA, 2014). Care remains strictly person-centered, focusing on the individual's goals and preferences (HIS, 2024). Consent must be treated as an iterative process throughout the recovery journey (HIS, 2024).

11.5. Addressing Inequities and System Governance

To ensure that no survivor is left behind, health systems must adopt a “whole-system approach” to quality of care that positions equity as a core dimension of patient safety (WHO, 2024). Governance frameworks must be sufficiently robust to mitigate systemic variations and guarantee sustainable, high-quality care for all populations (WHO, 2024).

- **Inclusive and Intersectional Follow-up Protocols:** Follow-up care must be tailored to the specific needs of underserved populations, including refugees, LGBTQI+ individuals, and people with disabilities (HIS, 2024). A truly effective response requires an **intersectional lens**, recognizing how multiple forms of discrimination - such as race, class, and gender identity - overlap to create unique barriers to recovery (EIGE, 2025).
- **Mitigating Structural and Systematic Barriers:** Survivors from marginalized groups often face high levels of “discontinuity of care” due to structural barriers, including language gaps, lack of legal documentation, or a justified fear of institutional discrimination (Bach et al., 2021). Facilities must mitigate these risks through flexible appointment scheduling, the provision of professional and independent translation services, and the active reduction of “gatekeeping” practices that prevent access for those without traditional support networks (Bach et al., 2021; HIS, 2024).
- **Intersectional Governance and Accountability:** Effective system governance requires the implementation of gender-sensitive and intersectional quality indicators to monitor service effectiveness across diverse demographics (EIGE, 2025). Collaborative leadership across agencies is essential to ensure that standards of care remain consistently high regardless of the survivor's background or geographical location (HIS, 2024; WHO, 2024).
- **Cultural Competence and Empowerment:** Every follow-up intervention must be culturally sensitive and person-centered, empowering survivors to remain the primary decision-makers in their recovery process (HIS, 2024). This approach requires continuous staff training on recognizing unconscious biases that may negatively influence clinical judgment or the quality of psychological support provided (Bach et al., 2021; EIGE, 2025).

11.6. The Follow-up Timeline Template

Timing	Focus Area	Key Actions
48–72 Hours	Safety & Adherence	Review injury pain; check PEP adherence; manage side effects.
1–2 Weeks	Symptoms & Choices	STI symptom review; pregnancy testing; re-offer options declined at first visit.
6 Weeks	Clinical Testing	Repeat STI screening; screen for acute stress reactions (O'Doherty et al., 2023).
3 Months+	Recovery & Health	Final STI/HIV testing window; monitor for chronic PTSD (Ullman & Peter-Hagene, 2023; O'Doherty et al., 2023).

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12. Referral Paths: Connecting Theory to Systemic Practice

12.1. Purpose and Systemic Scope

This section provides a clinical and operational roadmap for health professionals to identify, initiate, and complete safe referrals for women who have experienced sexual violence. Within the Greek health system, the professional acts as the primary “**entry point**” into a multi-sectoral ecosystem (UN Women, 2023). The objective is to facilitate a coordinated transition between health, justice, and social sectors while strictly maintaining survivor autonomy and confidentiality (GBV AoR, 2023; WHO, 2021).

Clinical Directive: To bridge the gap between clinical care and social protection, this framework must be used in direct conjunction with the **Support Services Directory (Annex 1)**, the **Forensic Services Map (Annex 2)**, and the **Police Services Directory (Annex 3)**.

12.2. Guiding Principles: The “How” of Safe Referral

A referral is not a paper-shuffling task; it is a trauma-informed clinical intervention (WHO, 2021).

- **Survivor-Centred & Trauma-Informed:** Believe and validate. The survivor must remain the primary decision-maker regarding which services to access and when. This stance reduces secondary victimization and improves long-term recovery outcomes (UN Women, 2022; WHO, 2021).
- **Informed Consent:** Before initiating any contact, the professional must explain the options, legal implications, and what specific data will be shared. Consent must be explicit and recorded (WHO, 2018, 2020).
- **Safety & Risk Awareness:** Decisions are guided by an immediate assessment of lethality risk. If the perpetrator is an intimate partner, the referral path must prioritize immediate physical protection (EIGE, 2018).

12.3. Integrated Referral Decision Tree (Hellenic Police)

Navigating the Greek police infrastructure requires a context-specific approach. Clinicians should use the following logic, as detailed in **Annex 3**:

1. **Immediate Threat to Life:** Call **100 (Emergency Action)** immediately. This line provides the fastest mobilization of uniformed response units.

2. **Domestic or Intimate Partner Violence:** Refer the survivor to a specialized **Domestic Violence Response Office (Annex 3.2)**.

- ✓ *Systemic Benefit:* These units are legally mandated to activate the **Panic Button** (geolocation alert) and coordinate immediate placement in **“Safe Houses”** (Hellenic Police, 2025; Law 5090/2024).

3. **Stranger or Non-Domestic Sexual Assault:** Refer to the local **Security Department (T.A.) (Annex 3.1)**.

- ✓ *Systemic Benefit:* These departments have the investigative expertise for felonies and the authority to issue the mandatory forensic (ιατροδικαστική) examination order (Law 5172/2025).

12.4. Core Referral Destinations: The “Menu” of Options

Survivors should be offered a choice-based menu of services based on their current priorities:

Sector	When to Refer	Purpose & Systemic Goal	Resource
Emergency	Immediately.	Rapid protection and guidance.	Annexes 1 (Helpline 15900) Annex 2 (Police emergency line 100)
Psychosocial	Acute distress.	Trauma-informed therapy and crisis counseling (WHO, 2021).	Annex 1
Forensic	Within 72–120h.	Mandatory DNA collection and legal documentation (U.S. Department of Justice, 2024).	Annex 2
Protection	High-risk cases.	“Panic Button” App, Emergency Shelters and Safe House access (Hellenic Police, 2025; Ministry of Social Cohesion and Family Affairs, 2023).	Annex 1 (Counselling centers for panic button and shelters) Annex 3 (Domestic Violence Response Offices for panic button & safe houses)

Sector	When to Refer	Purpose & Systemic Goal	Resource
Advocacy	Post-acute phase.	Help with housing, compensation, and court navigation (FRA, 2024).	Annex 1 (Counselling centers, NGOs)

12.5. The “Warm Handover” Standard

Professionals should avoid “passive” referrals (merely providing a leaflet).

- **The Warm Referral:** With consent, the professional directly calls the receiving agency (e.g., the specialized unit in **Annex 3.2**) to schedule the first appointment. This active connection reduces "survivor attrition," as the transition period is the point of highest dropout (NHS England, 2023; Scottish Government, 2022, April 1).
- **Survivor Navigation:** Ensure the survivor understands the specific role of each agency. Use the guidance from **Right Decisions** (HIS – SARCS, 2025, October 31) to explain the difference between clinical support and police investigative procedures.

12.6. Clinical Workflow: Step-by-Step Action Plan

1. **Recognize and Stabilize:** Provide first-line support via the **LIVES** framework (Listen, Inquire, Validate, Enhance safety, Support). Stabilize medical needs before pursuing legal referrals (WHO, 2021).
2. **Assess Risks:** Check for mental health crises and immediate safety threats (EIGE, 2018). If the perpetrator is a partner, discuss the “**Panic Button**” App, **Safe House** and **Shelters** options available via the units/services in Annexes 1.1 and Annex 3.2
3. **Explain Options:** Present the “menu” of services. Emphasize that survivors are entitled to healthcare regardless of their decision to report to the police (NHS England, 2023; Law 4478/2017).
4. **Obtain Informed Consent:** Document exactly what information will be shared with the receiving service (Annex 1, 2, or 3).
5. **Initiate Warm Referral:** Call the agency together with the survivor; confirm transport logistics and accompaniment (UN Women, 2022, Annexes 1.1. and 1.3.).
6. **Document and Follow-Up:** Use neutral, factual language in clinical notes. Establish a re-attendance plan for ongoing health needs (U.S. DOJ, 2024; WHO, 2020).

12.7. Addressing Specialized Support Needs

Referrals must be culturally competent. For **LGBTQI+ women, refugee women**, or those from **marginalized communities**, professionals should refer to specialized agencies (e.g., **HelpLine 11528** or NGOs in **Annex 1**) to ensure safety and prevent systemic bias (FRA, 2024; UN Women, 2022).

Refugee and Migrant Women: The referral must include a “safe-access” analysis, ensuring that the survivor is referred to NGOs that specialize in migration law to mitigate fears of deportation or status-related retaliation (FRA, 2024; UN Women, 2022). Professionals must ensure the survivor understands that her right to medical care and protection from violence is independent of her residence status.

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Final thoughts

What may matter most for the healthcare professional to carry forward from this publication is the understanding that, in situations of sexual violence, good care is shaped as much by how support is offered as by what is offered. Supporting a woman survivor of sexual violence begins with the recognition that the healthcare setting may represent her first, and sometimes only, point of contact with safety, care, and the wider support system. The quality of this first response can shape the entire pathway that follows. For this reason, privacy, calm, non-judgmental communication, and a trauma-informed, survivor-centred, and rights-based approach remain central throughout the encounter. Within that framework, informed consent is best understood as a continuous process, choice remains meaningful at every step, and the survivor's autonomy continues to guide the pace and scope of care.

It may also be important to retain that care after sexual violence often brings together several needs at once: urgent medical attention, emotional containment, safety assessment, documentation, possible forensic examination, and decisions about onward support. These elements do not stand apart from one another. Timely access to treatment, careful and purpose-limited history-taking, respectful examination, and accurate documentation all gain fuller value when carried out in ways that reduce distress and preserve the survivor's sense of control. In this context, clinical competence and relational sensitivity may be seen not as separate qualities, but as closely connected parts of the same professional responsibility.

Finally, one of the strongest messages running through these SOPs is that support rarely ends with the consultation itself. A meaningful healthcare response also keeps sight of what follows: safe discharge, clear follow-up, attention to barriers and vulnerabilities, and referral pathways that are active, understandable, and coordinated. The “warm handover” reflects this especially well, as it captures a broader vision of care—one in which the survivor is not left to navigate recovery, protection, and support alone. Perhaps the essential point to remain most present is that the role of the healthcare professional extends beyond treatment alone and may become a decisive part of a survivor's pathway toward safety, continuity, and recovery.

ANNEXES

Annex 1. Support Services Directory (psychosocial and legal support, shelters, helplines, etc.)

1.1. Women's Counseling Centers

The 14 Counseling Centers of the Research Centre for Gender Equality (**KETHI**), the 31 Municipal Women's Counseling Centers, and the 1 Counseling Center of the General Secretariat for Equality and Human Rights (**GSEHR**) are part of the Network of support structures for the prevention and combating of violence and multiple discrimination against women of the GSEHR and are co-financed by the Regional Operational Programmes (ROP) of the NSRF 2021-2027 of the respective Regions.

The Counseling Centers provide **FREE** and **CONFIDENTIAL** counseling support services to any woman who suffers from any form of violence or discriminatory treatment, specifically:

The services are covered by counseling confidentiality and concern:

- **provision of information and specialized counseling** on gender equality issues, combating gender-based violence, and multiple discrimination against women
- **provision of social, psychological, legal, and employment counseling support** (through a gender perspective)
- **completion**, in collaboration with the beneficiary and if required, of a **risk assessment tool**
- **development**, in collaboration with the beneficiary and if required, of a **safety plan**
- **referral and/or accompaniment** —whenever required— of women to hosting shelters, police and prosecutorial authorities, courts, health structures, agencies responsible for welfare or other benefits, employment and entrepreneurship agencies, child protection and support agencies, etc.
- **provision**, in collaboration with bar associations, of **free legal representation (legal aid)** to women survivors of gender-based violence
- **integration** of beneficiaries into active employment programs of the Public Employment Service (**DYPA**)
- **installation** of the "**Panic Button**" application (Government Gazette 2922/B/23-5-2024) on women's smartphones; notably, any prior legal action on the part of the women is not a prerequisite for the Counseling Centers to facilitate this.

Contact information and addresses of Counseling Centers:

- **The GSEHR Counseling Center:**
Athens Counseling Center (Organic Structure of GSEHR)
 Address: 11 Nikis St., PC 105 57, Syntagma

Tel.: (+30) 2103317305-6
E-mail: isotita4@otenet.gr

- **The 14 Counseling Centers of KETHI (in alphabetical order):**

- **Athens Counseling Center – POLYKENTRO**
Hours: Monday to Friday 09:00-17:00
Address: 11-13 Kratinou St., Omonoia 105 52 (2nd floor)
Tel.: (+30) 2105202800
E-mail: polykentro@isotita.gr
- **Corfu Counseling Center**
Hours: Monday to Friday 08:00 – 16:00
Address: 7 Ethnikis Paleokastritsas Rd., 49 100 Corfu
Tel.: (+30) 2661047396
E-mail: kerkyra@isotita.gr
- **Heraklion Counseling Center**
Hours: Monday to Friday 08:00-16:00
Address: 3 Stanimachou St., PC 713 05, Heraklion, Crete
Tel.: (+30) 2810341387
E-mail: irakleio@isotita.gr
- **Ioannina Counseling Center**
Hours: Monday to Friday 08:00-16:00
Address: 68 Marikas Kotopouli St., 45 445 Ioannina
Tel.: (+30) 26510 77449
E-mail: ioannina@isotita.gr
- **Komotini Counseling Center**
Hours: Monday to Friday 08:00-16:00
Address: Konstantinou Paleologou St. (Municipal Market), 69 132 Komotini
Tel.: (+30) 2531033290
E-mail: komotini@isotita.gr
- **Kozani Counseling Center**
Hours: Monday to Friday 08:00-16:00
Address: 5 Rodopis St., PC 50 100, Kozani
Tel.: (+30) 2461049672
E-mail: kozani@isotita.gr
- **Lamia Counseling Center**
Hours: Monday to Friday 08:00-16:00
Address: 27 Patroklou St., Lamia, 351 00
Tel.: (+30) 22310 20059
E-mail: lamia@isotita.gr
- **Larissa Counseling Center**
Hours: Monday to Friday 08:00-16:00
Address: 4 Galinou St., 412 22, Larissa (3rd floor)
Tel.: (+30) 2410535840
E-mail: larisa@isotita.gr
- **Mytilene Counseling Center**
Hours: Monday to Friday 08:00-16:00
Address: 17 Vournazon St., PC 811 00, Mytilene

Tel.: (+30) 2251034470

E-mail: mytilini@isotita.gr

➤ **Patras Counseling Center**

Hours: Monday to Friday 08:00-16:00

Address: 101b Kanakari St., Patras, 262 21

Tel.: (+30) 2610620059

E-mail: patra@isotita.gr

➤ **Piraeus Counseling Center**

Hours: Monday to Friday 09:00-17:00

Address: Ethnarchou Makariou Ave., Neo Faliro, PC 185 47 (within Peace and Friendship Stadium-SEF, ground floor)

Tel.: (+30) 2104828970, 4825372

E-mail: peiraias@isotita.gr

➤ **Syros Counseling Center**

Hours: Monday to Friday 08:00-16:00

Address: 2 Folegandrou St., PC 84 100, Ermoupoli, Syros

Tel.: (+30) 22810 76496

E-mail: ermoupoli@isotita.gr

➤ **Thessaloniki Counseling Center**

Hours: Monday to Friday 09:00-17:00

Address: 10 Alexandroupoleos St. (Western Entrance), Thessaloniki, 54627

Tel.: (+30) 2310528984, 528988

E-mail: thessaloniki@isotita.gr

➤ **Tripoli Counseling Center**

Hours: Monday to Friday 08:00-16:00

Address: Ioanni Papadimitriou-Professor of Surgery St., New Municipal Market Square, PC 22131, Tripoli

Tel.: (+30) 2710241814

E-mail: tripoli@isotita.gr

• **The 32 Municipal Counseling Centers (in alphabetical order):**

- | |
|--|
| ➤ Agioi Anargyroi-Kamatero Municipal Counseling Center |
| Address: N. Zerva & Navarinou, Postal Code 13451, Kamatero |
| Phone: (+30) 213 212 5165-6 |
| E-mail: isotita@agankam.gov.gr |
| ➤ Athens Municipal Counseling Center |
| Address: 2 Agiou Meletiou & Lithis St., 112 51 Athens |
| Tel.: (+30) 210 8625355, 210 8625858 |
| E-mail: kentrokatapolemisisdiakriseon@athens.gr |
| ➤ Alexandroupoli Municipal Counseling Center |
| Address: New Municipal Indoor Swimming Pool, PC 681 00, Alexandroupoli |
| Tel.: (+30) 2551025629 |
| E-mail: isotita@alexpolis.gr |
| ➤ Arta Municipal Counseling Center |
| Address: 24 Tzavella St., PC 471 32, Arta |
| Tel.: (+30) 2681077400 |
| E-mail: skgarta@gmail.com |

- **Chalandri Municipal Counseling Center**
Address: 7 Stratarchou Alexandrou Papagou St., PC 152 34, Chalandri
Tel.: (+30) 2106899916
E-mail: womenaidhalandri@gmail.com
- **Chalkida Municipal Counseling Center**
Address: Social Policy Department of the Municipality of Chalkida, 27 Glavkou St., PC 34100, Chalkida
Tel.: (+30) 2221060154
E-mail: skg.xalkideon@dchalkideon.gr
- **Chios Municipal Counseling Center**
Address: 27 Veriti St., Kammenos Pyrgos, PC 821 00, Chios
Tel.: (+30) 2271350040
E-mail: womanaid@outlook.com
- **Corinth Municipal Counseling Center**
Address: 58 Ethnikis Anexartias St., PC 201 31, Corinth
Tel.: (+30) 2741074670
E-mail: skgyndk@otenet.gr
- **Drama Municipal Counseling Center “Aithra”**
Address: Nikomideias & Ethnikis Epanastaseos, PC 66100, Drama
Tel.: (+30) 2521351066
e-mail: symvken@dimosdramas.gr
- **Elefsina Municipal Counseling Center**
Address: 70 Riga Feraiou St., Dimokratias Sq., PC 192 00 Elefsina
Tel.: (+30) 2131601437
E-mail: violence@1822.syzefxis.gov.gr
- **Florina Municipal Counseling Center**
Address: 49 Kontopoulou St., PC 531 00, Florina
Tel.: (+30) 2385024081
E-mail: symv.kentro.flo@gmail.com
- **Fyli Municipal Counseling Center**
Address: 23 I. Kampoli St., PC 133 41, Ano Liosia
Tel.: (+30) 2102483360
E-mail: ksfylis@fyli.gr
- **Kalamata Municipal Counseling Center**
Address: Perrotou & Mantiklou St., PC 241 00, Kalamata
Tel.: (+30) 2721099212, 99225
E-mail: ksg@kalamata.gr
- **Karditsa Municipal Counseling Center**
Address: 22 Heroon Polytechneiou St., PC 431 32, Karditsa
Tel.: (+30) 2441071594, 24410 77122
E-mail: info@wck.gr & wckarditsa@gmail.com
- **Kastoria Counseling Center**
Address: Chloe Area, New Labour Housing, PC 521 00, Kastoria
Tel.: (+30) 2467022122
E-mail: counsellingwomenkastoria@gmail.com
- **Katerini Municipal Counseling Center**
Address: 21 Avgoustinou St., PC 601 00, Katerini
Tel.: (+30) 2351036678

- E-mail: womenaid@katerini.gr
- **Kavala Municipal Counseling Center**
Address: 9 K. Paleologou St., PC 654 03, Kavala
Tel.: (+30) 2513500440, 2513500441, 2513500442, 2513500443
E-mail: womensaid@kavala.gov.gr
 - **Kefalonia Municipal Counseling Center**
Address: 46 P. Charokopou St., PC 281 00, Argostoli
Tel.: (+30) 2671020022
E-mail: kesy@kefallonia.gov.gr
 - **Keratsini-Drapetsona Municipal Counseling Center**
Address: 25is Martiou & Dominikou Theotokopoulou St., PC 186 48, Drapetsona
Tel.: (+30) 2104614575
E-mail: skkeratsini@gmail.com
 - **Kos Municipal Counseling Center**
Address: 25is Martiou & E. Kiapoka St. (corner), Zipari, PC 853 00, Kos
Tel.: (+30) 2242067420
E-mail: women@kos.gr
 - **Peristeri Municipal Counseling Center**
Address: 1 Ethnarchou Makariou St. (KYBE building), PC 121 31, Peristeri
Tel.: (+30) 2105783265
E-mail: skg@peristeri.gr
 - **Preveza Municipal Counseling Center**
Address: 6 Ionias St., PC 481 00, Preveza
Tel.: (+30) 2682024444
E-mail: womenaid@1485.syzefxis.gov.gr
 - **Pyrgos Municipal Counseling Center**
Address: Gymnasiahou Douka & Xanthou St., PC 271 31, Pyrgos
Tel.: (+30) 2621020532
E-mail: pirgoswomen@outlook.com
 - **Rethymno Municipal Counseling Center**
Address: 98 L. Kountouriotou Ave., PC 741 00, Rethymno
Tel.: (+30) 2831056607
E-mail: isotitavia.reth@gmail.com
 - **Rhodes Municipal Counseling Center**
Address: 51-53 Ethnikis Antistaseos St. (1st floor), PC 85133, Rhodes
Tel.: (+30) 2241067155, 67120, 67123, 67128
E-mail: ksymbouleytikorodou@gmail.com
 - **Salamina Municipal Counseling Center**
Address: 15 Agiou Petrou St., Ampelakia Salaminas, PC 18902
Tel.: (+30) 2104672665
E-mail: women@salamina.gov.gr
 - **Serres Municipal Counseling Center**
Address: Ionos Dragoumi St., PC 621 22, Serres
Tel.: (+30) 2321022253
E-mail: womenaid@serres.gr
 - **Thebes Municipal Counseling Center**
Address: 3 Kyprou St., PC 322 00, Thebes
Tel.: (+30) 2262089574, 89576

- E-mail: symvouleutiko@thiva.gr
- **Trikala Municipal Counseling Center**
Address: Theodosopoulou & Tzoumagias St. (opposite DEI), PC 421 00, Trikala
Tel.: (+30) 2431027943
E-mail: skg@trikalacity.gr
 - **Veria Municipal Counseling Center**
Address: 3A Kapetan Agra St., PC 591 31, Veria
Tel.: (+30) 2331065304
E-mail: isotita@veria.gr
 - **Xanthi Municipal Counseling Center "Zoi Dalaklidou"**
Address: 30 Venizelou St., PC 67132, Xanthi
Tel.: (+30) 2541066304
E-mail: simvouleftiko@cityofxanthi.gr
 - **Zakynthos Municipal Counseling Center**
Address: Gaitani (Community Office), PC 291 00, Zakynthos
Tel.: (+30) 2695025997
E-mail: symvouleftikozakynthos@gmail.com

1.2. Helplines

1.2.1 SOS Helpline 15900 (24-hour)

24-hour telephone line of the GSEHR for women victims of violence. Provides information and telephone counseling to survivors of violence. Operates 24/7, seven days a week, throughout the year.

1.2.2. Social Aid Line 197 (24-hour)

24-hour social aid telephone line of the National Centre for Social Solidarity (**EKKA**). Provides emergency counseling and psychological support to adults, immediate information on social welfare and mental health issues, mobilizes emergency field social intervention mechanisms, refers to other EKKA services and structures, as well as connects individuals needing further help with other competent Services, Organizations, and Social Care Structures; it also receives and transmits reports to the competent Prosecutorial Authorities concerning the neglect and/or abuse of adults, primarily the elderly or persons with disabilities.

1.2.3. Suicide Intervention Line 1018 (24-hour)

The 24-hour telephone Suicide Intervention Line 1018 is operated by the NGO "Klimaka". It is addressed to people who are thinking of committing suicide, who have attempted suicide in the past, with self-destructive behavior and/or experiencing loss, or who are concerned about a loved one. Operates 24/7, seven days a week, throughout the year.

1.2.4. Helpline for LGBTQI+ individuals 11528

11528 psychological support telephone line for LGBTQI+ individuals: psychological support for gay, lesbian, bi, trans, queer, intersex persons, their families, and educators. Operates Monday – Friday, 10 am - 6 pm.

1.2.5. National Psychosocial Support Line 10306 (24-hour)

Addressed to citizens of all genders and ages for **any mental health issue** that concerns them (e.g., anxiety, family issues, grief, panic attacks). Also, provides the possibility of referral to a Mental Health Center (**KPS**), as well as information on mental health services. Operates 24/7, seven days a week, throughout the year.

1.3. Non-Governmental Organizations

1.3.1. Center for Gender Rights and Equality “Diotima” (www.diotima.org.gr)

Based in Athens, provides —free and confidential— support services aimed at the support and empowerment of women and feminine identities experiencing gender-based violence and having limited economic and/or social resources. Specifically, it provides:

- **legal counseling and court representation** to Greek, migrant, and refugee women residing in the Regions of Attica and Central Macedonia
- **psychosocial support**, through individual sessions, to Greek, migrant, and refugee women residing in the Regions of Attica and Central Macedonia, and remote sessions for women residing in other parts of the country
- **referral** to services and structures, depending on the woman's needs (housing, healthcare)
- **individualized professional counseling** to unemployed and working survivors of gender-based violence and others (Greek, migrant, and refugee women). Our goal is to facilitate their access to the labor market, develop/upgrade their skills, and empower them to achieve their financial independence.

Contact:

- For Attica, Monday-Friday, 9:30–17:30, tel. (+30) 2103244380 or email helpdesk.diotima@gmail.com.
- For Central Macedonia: Monday-Friday, 9:00–17:00, (+30) 2310534445 or email urban.thessaloniki.diotima@gmail.com

1.3.2. European Network against Violence (www.antiviolence-net.eu)

Provides —free and confidential— the following services to survivors:

- **information** for domestic violence survivors and their connection to service provision structures (shelters, counseling centers, etc.)

- **assistance and holistic support** for abused women [e.g., information, empowerment, psychosocial, legal, educational, employment support, coverage of basic needs (e.g., clothing), accompaniment services (e.g., to the police, the forensic service, the hospital, the court), support on issues concerning their children], in-person and/or via telephone.

Contact: Tel. (+30) 2109225491, e-mail info@antiviolence-net.eu

1.3.3. YWCA (XEN) Greece (www.xen.gr)

Based in Athens—but with a presence in various parts of the country— provides (among others) —free and confidential— the following services:

- **psychosocial support** through individual counseling, information, networking, and referral to competent agencies, for women trying to adapt to a change in their life, seeking information for social support on an issue that concerns them and not knowing where to turn, needing individualized information on services provided by the community for their own or a loved one's issue, struggling with the management of a challenge/frustration, or experiencing internal or interpersonal relationship difficulties
- **housing and individualized psychosocial support and career counseling** to young women, students of University Schools of Attica, permanently residing outside the prefecture
- **career counseling** to unemployed women wishing to enter or re-enter the labor market, employees interested in life-long career management, women wanting to start their own business, special population groups threatened by social exclusion, and mothers wanting to return to the professional field.

Contact: tel. (+30) 2103624291 & (+30) 2103606530, email info@xen.gr

1.3.4. “Asterodeia” - Greek Center for the Protection of Women and Motherhood (www.asterodeia.gr)

Based in Athens, provides (among others) —free and confidential— legal counseling, psychosocial support, and psychotherapy for vulnerable individuals who are victims of domestic violence, in collaboration with mental health structures.

Contact: tel. (+30) 2114441875, e-mail info@asterodeia.gr

1.3.5. “Vges sto Fos” (Come to Light) - Association for the Support and Protection of Impoverished and Abused Women, Adolescents, and Children (www.vgesstofos.gr)

Based in Piraeus, provides (among others) —free and confidential— the following services:

- **legal support** for abused women & children
- **psychological support and empowerment groups** for women-adolescents-children.
- **financial aid** and provision of **free** goods, food, basic necessities (clothing, footwear), soup kitchens

- **immediate medical care** and health promotion for impoverished, abused women and children
- **information** for the impoverished to benefit from state welfare benefits, as well as completion of procedures with the help of the association.

Contact:

- Tel. (+30) 2160014100, e-mails info@vgesstofos.gr & vgesstofos2023@gmail.com
- Also, for immediate response, reports, and service for victims and their families, interested parties can call 24/7 at (+30) 698415696

1.3.6. Center for Managing Gender Inequalities “ERIFYLI” (www.erifyli.org)

Active in Patras, offering (among others) —free and confidential— the following services:

- **legal counseling**
- **psychological support**
- **drafting an escape plan** from an abusive relationship and legal actions in collaboration with the agency's network of legal partners
- **empowerment** of feminine identities through information about their rights and advocacy for claiming them
- **mental empowerment and skill development/utilization workshops.**

Contact: tel. (+30) 2610334655, e-mail erifyli.org@gmail.com

1.3.7. Association of Members of Women's Associations of Heraklion & Prefecture of Heraklion (www.kakopoiisi.org.gr)

Based in Heraklion, Crete, provides (among others) —free and confidential— the following services:

- **legal counseling**
- **psychological support**
- **social support**
- **hosting/shelter**
- **support in employment reintegration.**

Contact:

- Tel. (+30) 2810242121 & (+30) 6974301011 (from landline & mobile), email info@kakopoiisi.gr
- Also, the emergency telephone number (+30) 8011116000 (landline only) operates 24/7.

1.4. Holy Archdiocese of Athens

1.4.1. “Protovoulia” (Initiative) Program of the Women's Affairs Service of the Youth Foundation of the Holy Archdiocese of Athens (www.protovoulia-prolipsi.gr)

“Protovoulia” was established by the Women's Affairs Service of the Youth Foundation of the Holy Archdiocese of Athens, yet it is the product of collaboration with the Holy Metropolis of Ilion, Acharnes, and Petroupoli, the Region of Attica, the Municipality of Athens, and the Hellenic Police.

Within the framework of the Program, a telephone helpline operates for awareness, information, and referral regarding domestic violence incidents. Any citizen, whether an adult or a minor, who is either directly involved in domestic violence incidents or has noticed suspicious activity within their immediate or broader social environment, may contact the collaborating professionals (Psychologist and Social Worker) who manage the Helpline. The collaborating professionals receive—guided by the principles of active listening and confidentiality—the request of every interested individual and refer them to the appropriate counseling or social welfare structures and competent Services.

Contact: (+30) 2102023568, Monday - Thursday 09:00-17:00

Annex 2. Forensic Services Map

Name	Contact Phone	E-mail
Aegean Forensic Service (8 Ladopoulou St., Ermoupoli)	(+30) 2281085004	iatrodikastikisyrou@gmail.com
Athens Forensic Service (10 Anapafseos St.)	(+30) 2109244900, (+30) 2109219002	iatrodikastiki-athinon@moj.gov.gr
Corfu Forensic Service (5th 3rd alley of Eleftheriou Venizelou St., New Harbor)	(+30) 2661082243	iatrodikastiki-kerkyras@moj.gov.gr
Crete Forensic Service (259 Knossou Ave. & Nathena, Heraklion)	(+30) 2810324040	ihraklio@otenet.gr
Dodecanese Forensic Service (108 Georgiou Seferi St., Rhodes)	(+30) 2241022678	iatrodikastiki-dodekanisou@moj.gov.gr
Lamia Forensic Service (Terma Papasiopoulou, General Hospital)	(+30) 2231039197, (+30) 2231038550, (+30) 2231356272	corlamia@otenet.gr
Larissa Forensic Service (73 Panagouli St.)	(+30) 2410549815, (+30) 2410549805	iatrodikastiki-larisas@moj.gov.gr , nekrotomeio-larisas@moj.gov.gr
Nafplio and Kalamata Forensic Service (2 Kyprou St., Nafplio)	(+30) 27520 99033	iatronav@otenet.gr
North Aegean Forensic Service (48 E. Vostani St., Mytilene)	(+30) 2251054558	iatrodikastiki-voreiouaigaou@moj.gov.gr
Patras Forensic Service (Patras University Hospital «Panagia Voithia»)	(+30) 2613603932	idkpatras@pgnp.gr
Piraeus Forensic Service 1 (31-33 Dimitriou Gounari St.)	(+30) 2104177876, (+30) 2104110551, (+30) 2104177502	iatrodikastiki-peiraia@moj.gov.gr
Piraeus Forensic Service 2 («ANASTASI» Cemetery, End of Anastaseos St.)	(+30) 2104613904	iatrodikastiki-peiraia@moj.gov.gr
Thessaloniki Forensic Service (P.O. Box 771 / PC 57008, Ionia Thessaloniki)	(+30) 2310550413, (+30) 2310550416	iatrodikastiki-thessalonikis@moj.gov.gr
Thrace Forensic Service (59 Filikis Etaireias St., Komotini)	(+30) 2531085692, (+30) 2531085693, (+30) 2531080162, (+30) 2531080163	iatrodikastiki-thrakis@moj.gov.gr
Western Macedonia Forensic Service (1 Mamatsiou St., Kozani)	(+30) 2461033568	iatrodikastiki-dytikismakedonias@moj.gov.gr

Annex 3. Police Services

For any **emergency, reporting, or immediate guidance**, the telephone line **100** (Emergency Action) should be the first point of contact, followed by the **15900** (SOS Line), both of which are available 24/7. In the event of rape or sexual assault, a survivor can also immediately contact the nearest **Security Department (“Τμήματα Ασφάλειας” - T.A.)**, which is the competent authority for conducting preliminary investigations and ordering the mandatory forensic medical examination. If the assault is committed by a spouse, partner, or family member, the complaint can be filed at the specialized **Domestic Violence Response Offices** of the Hellenic Police; these offices provide enhanced protection - such as the **Panic Button** application and access to **“Safe Houses”** - and are staffed by specially trained personnel.

3.1. Security Departments

3.1.1. Central Security Departments (Primary Points of Reference)

These departments coordinate local branches and possess the specialized expertise required for high-priority cases:

Region	Service	Address	Telephone
Athens (Central)	Attica Security Directorate	173 Alexandras Ave., 115 22	(+30) 210 6476000
Piraeus	Piraeus Security Sub-directorate	37 Ir. Polytechneiou St., 185 32	(+30) 210 4178714
N/E Attica	N/E Attica Security Sub-directorate	16 Ag. Orous St., Marousi, 151 23	(+30) 210 6875197
West Attica	West Attica Security Sub-directorate	21 Marmara St., Egaleo, 122 42	(+30) 210 5319295
S/E Attica	S/E Attica Security Sub-directorate	Former East Airport, 167 77	(+30) 210 9690810
Thessaloniki	Thessaloniki Security Directorate	326 Monastiriou St., 546 28	(+30) 2310 388000

3.1.2. Security Departments in Provincial Capitals (excluding Attica and Thessaloniki)

Prefecture	Capital	Service Title	Address	Telephone
Achaea	Patras	Security Sub-directorate	95 Ermou St.	(+30) 2610 695000
Aetoloacarnania	Messolonghi	Security Department	10 Papadiamantopoulou St.	(+30) 26310 55712
Arcadia	Tripoli	Security Department	1 Ag. Dimitriou St.	(+30) 2710 230557
Argolida	Nafplio	Security Department	Ethnasynelefsis Sq.	(+30) 27520 98747
Arta	Arta	Security Department	Ethn. Antistasis Sq.	(+30) 26810 80146
Boeotia	Livadeia	Security Department	51 Philonos St.	(+30) 22610 88855
Cephalonia	Argostoli	Security Department	1 L. Vergoti Ave.	(+30) 26710 27842
Chalkidiki	Polygyros	Security Department	25th Martiou St.	(+30) 23710 21635
Chania	Chania	Security Sub-directorate	23 Irakleiou Ave.	(+30) 28210 30760
Chios	Chios	Security Sub-directorate	1 Polemidi St.	(+30) 22714 40550
Corfu	Corfu	Security Sub-directorate	1 Ioulia Andreadi St.	(+30) 26610 29170
Corinthia	Corinth	Security Department	51 Ermou St.	(+30) 27410 77214
Cyclades	Ermoupoli	Security Department	Kanari Sq.	(+30) 22810 96185
Dodecanese	Rhodes	Security Sub-directorate	43 Synt. Ethel. Dodekanisou St.	(+30) 22410 44138
Drama	Drama	Security Department	13 1is Iouliou St.	(+30) 25210 31111
Elis (Ilia)	Pyrgos	Security Sub-directorate	1 Dionysou St.	(+30) 26210 81740
Euboea	Chalcis	Security Department	153 Arethousis St.	(+30) 22210 37031
Evros	Alexandroupoli	Security Sub-directorate	6 Karaiskaki St.	(+30) 25510 66220
Evrytania	Karpenisi	Security Department	9 Ethnikis Antistaseos St.	(+30) 22370 89170

Prefecture	Capital	Service Title	Address	Telephone
Florina	Florina	Security Department	1 28th Oktovriou St.	(+30) 23850 44221
Grevena	Grevena	Security Department	45 Makrygianni St.	(+30) 24620 22401
Heraklion	Heraklion	Security Sub-directorate	1 Agiou Artemiou St.	(+30) 2810 274000
Imathia	Veria	Security Department	1 Mitropoleos St.	(+30) 23310 76661
Ioannina	Ioannina	Security Sub-directorate	11 28th Oktovriou St.	(+30) 26510 65900
Karditsa	Karditsa	Security Department	Plastira & Kolokotroni St.	(+30) 24410 80234
Kastoria	Kastoria	Security Sub-directorate	60 Parodos Grammou St.	(+30) 24674 40205
Kavala	Kavala	Security Department	119 Omonoias St.	(+30) 2510 622267
Kilkis	Kilkis	Security Department	3 G. Kampouroglou St.	(+30) 23410 77028
Kozani	Kozani	Security Department	1 Aristophanous St.	(+30) 24610 54430
Laconia	Sparta	Security Department	Philosophia Ave.	(+30) 27310 89612
Larissa	Larissa	Security Sub-directorate	92 Papanastasiou St.	(+30) 2410 683208
Lasithi	Agios Nikolaos	Security Sub-directorate	47 Erythrou Stavrou St.	(+30) 28410 91413
Lefkada	Lefkada	Security Department	30 Ir. Polytechneiou St.	(+30) 26450 29359
Lesbos	Mytilene	Security Sub-directorate	3 P. Kountouriotou St.	(+30) 22510 58870
Magnesia	Volos	Security Sub-directorate	69 Kartali Konstantinou St.	(+30) 24210 76935
Messenia	Kalamata	Security Sub-directorate	Iroon Polytechneiou	(+30) 27210 44646
Pella	Edessa	Security Department	13 Ir. Polytechneiou St.	(+30) 23810 51723
Phocis	Amfissa	Security Department	Salonon & K. Karamanli St.	(+30)22650 79417
Phthiotis	Lamia	Security Department	Athinon Ave.	(+30) 22310 56868
Pieria	Katerini	Security Sub-directorate	28th Oktovriou	(+30) 23510 46633

Prefecture	Capital	Service Title	Address	Telephone
Preveza	Preveza	Security Department	31 Polytechneiou St.	(+30) 26820 89542
Rethymno	Rethymno	Security Sub-directorate	26 Ir. Polytechneiou Sq.	(+30)28310 88100
Rhodope	Komotini	Security Department	3 Dimokratias St.	(+30)25310 83230
Samos	Vathy	Security Sub-directorate	3 Pr. Nikolareizi St.	(+30) 22730 87314
Serres	Serres	Security Sub-directorate	3 Kerasountos St.	(+30)23210 90915
Thesprotia	Igoumenitsa	Security Department	5 Ag. Apostolon St.	(+30) 26650 29655
Trikala	Trikala	Security Sub-directorate	Giannitson & Pharmaki St.	(+30) 24314 39899
Xanthi	Xanthi	Security Department	2 Nestou St.	(+30) 25410 84122
Zakynthos	Zakynthos	Security Department	62 Lombardou St.	(+30) 26950 24492

How to Locate Your Local Department (Digital Reference Tool):

Because addresses and phone numbers may change (or departments may merge under the new "Crime Prosecution and Detection Department" naming convention), the most reliable source is the **Hellenic Police Digital Service Locator**.

- **Link:** www.astynomia.gr/anazitisi-ypiresion
- **Instructions:** Select the Prefecture (e.g., Attica) and search for the terms "Security Department" (Τμήμα Ασφαλείας) or "Crime Prosecution and Detection Department" (Τμήμα Δίωξης και Εξιχνίασης Εγκλημάτων).

3.2. Domestic Violence Response Offices

3.2.1. Domestic Violence Response Offices (Attica & Thessaloniki)

Region	Prefecture/Area	Local Office (A.T.)	Address	Telephone
Attica	Athens (Central)	Omonia	8 Veranzerou St.	(+30) 210 5286154
Attica	Athens (Central)	Kypseli	102 Kypselis St.	(+30) 210 8258525
Attica	Athens (Central)	Ambelokipi	173 Alexandras Ave.	(+30)210 6476100
Attica	Athens (North)	Marousi	27 25th Martiou St.	(+30)210 6875044
Attica	Athens (North)	Agia Paraskevi	23 Messogeion Ave.	(+30) 210 6069941
Attica	Athens (South)	Kallithea	166 Laskaridou St.	(+30) 210 9542037
Attica	Athens (South)	Glyfada	45-47 Alsous St.	(+30) 210 8984360
Attica	Athens (West)	Peristeri	21-23 Marmara St.	(+30) 210 5319326
Attica	Athens (West)	Egaleo	16-18 Marmara St.	(+30) 210 5319405
Attica	Piraeus	Piraeus Central	37 Ir. Polytechneiou St.	(+30) 210 4170701
Attica	Piraeus	Dimotiko Theatro	13 Karaoli & Dimitriou	(+30) 210 4111300
Thessaloniki	City Center	Monastiriou	326 Monastiriou St.	(+30) 2310 388372
Thessaloniki	City Center	Lefkos Pyrgos	1 Aristotelous Sq.	(+30) 2310 273613
Thessaloniki	Kalamaria	Kalamaria	2 Metamorphoseos St.	(+30) 2310 411030
Thessaloniki	Evosmos	Kordelio-Evosmos	1 Karaoli & Dimitriou	(+30) 2310 758666

3.2.2. Domestic Violence Response Offices (Rest of Greece)

Prefecture	City/Office	Address	Telephone
Achaea	Patras	95 Ermou St.	(+30) 2610 695191
Aetoloacarnania	Agrinio	14 Polyzoidi St.	(+30) 26410 22520
Arcadia	Tripoli	1 Ag. Dimitriou St.	(+30) 2710 230551
Argolida	Nafplio	10 Plastira St.	(+30) 27520 98700
Arta	Arta	Ethnikis Antistasis Sq.	(+30) 26810 80100
Boeotia	Livadeia	51 Philonos St.	(+30) 22610 88800
Chalkidiki	Polygyros	25th Martiou St.	(+30) 23710 21610
Chania	Chania	23 Irakleiou Ave.	(+30) 28210 25856
Chios	Chios	1 Polemidi St.	(+30) 22710 81500
Corfu	Corfu	1 Ioulias Andreadi St.	(+30) 26610 29146
Corinthia	Corinth	51 Ermou St.	(+30) 27410 77202
Cyclades	Syros (Hermoupolis)	Kanari Sq.	(+30) 22810 96100
Dodecanese	Rhodes	43 Ethelonton Dodec.	(+30) 22410 23278
Drama	Drama	13 1is Iouliou St.	(+30) 25210 60000
Elis (Ilia)	Pyrgos	1 Dionysou St.	(+30) 26210 81730
Euboea	Chalcis	153 Arethousis St.	(+30) 22210 37000
Evros	Alexandroupoli	6 Karaiskaki St.	(+30) 25510 66250
Florina	Florina	1 28th Oktovriou St.	(+30)23850 44200
Heraklion	Heraklion	1 Agiou Artemiou St.	(+30) 2810 274147
Imathia	Veria	1 Mitropoleos St.	(+30) 23310 76600
Ioannina	Ioannina	11 28th Oktovriou St.	(+30) 26510 65977
Karditsa	Karditsa	Plastira & Kolokotroni	(+30) 24410 80200
Kastoria	Kastoria	Parodos Grammou 60	(+30) 24670 21500
Kavala	Kavala	119 Omonoias St.	(+30) 2510 622200
Kilkis	Kilkis	3 G. Kampouroglou St.	(+30) 23410 77000
Kozani	Kozani	1 Aristophanous St.	(+30) 24610 54400
Laconia	Sparta	Philosophia Ave.	(+30) 27310 89600
Larissa	Larissa	92 Papanastasiou St.	(+30) 2410 683171
Lasithi	Agios Nikolaos	47 Erythrou Stavrou	(+30) 28410 91400
Lesbos	Mytilene	3 P. Kountouriotou	(+30) 22510 58800
Magnesia	Volos	69 Kartali St.	(+30) 24210 76900
Messenia	Kalamata	Iroon Polytechneiou	(+30) 27210 44600
Pella	Edessa	13 Ir. Polytechneiou	(+30) 23810 51700
Pieria	Katerini	28th Oktovriou St.	(+30) 23510 46600
Preveza	Preveza	31 Polytechneiou St.	(+30) 26820 89500
Rethymno	Rethymno	26 Ir. Polytechneiou	(+30) 28310 88155

Prefecture	City/Office	Address	Telephone
Rhodope	Komotini	3 Dimokratias St.	(+30) 25310 83200
Samos	Samos	3 Pr. Nikolareizi	(+30)22730 87300
Serres	Serres	3 Kerasountos St.	(+30) 23210 90900
Trikala	Trikala	Giannitson & Pharmaki	(+30) 24310 63300
Xanthi	Xanthi	2 Nestou St.	(+30) 25410 84100