

MEDICO-LEGAL ANALYSIS OF SODOMY CASES REFERRED TO THE BAGHDAD MEDICO-LEGAL DIRECTORATE OVER A TWO-YEAR PERIOD (2023–2024): A RETROSPECTIVE DESCRIPTIVE STUDY

Fouad Abdulhameed Qaddoori^{1*},

Dr. Nabeel Ghazi Hashim²

¹ M.B.Ch.B., Medico-Legal Directorate, Baghdad, Iraq

² M.B.Ch.B., M.Sc., F.I.B.M.S. (Forensic Medicine), College of Medicine,
University of Baghdad, Baghdad, Iraq
nabeelghazihashim@comed.uobaghdad.edu.iq

*Corresponding author: Fouad Abdulhameed Qaddoori

Email: fouad.abdulhameed.a@gmail.com

Abstract:

Background: Allegations of sodomy present distinctive challenges in forensic practice, requiring a balance between clinical objectivity and legal responsibility. Reliable local data on the magnitude and pattern of medico-legally confirmed cases are scarce in Iraq.

Objectives: To describe the frequency, demographic distribution, and documented physical findings of medico-legally confirmed sodomy cases referred to the Baghdad Medico-Legal Directorate during 2023–2024, and to examine their association with sex, age, type of finding, and month of presentation.

Methods: A retrospective, single-centre, records-based descriptive study was conducted in the Department of Forensic Living Examination and the Clinical Management of Rape Unit of the Baghdad Medico-Legal Directorate. All 381 examinations performed for an isolated request of sodomy examination between 1 January 2023 and 31 December 2024 were reviewed; record retrieval and data analysis were carried out between January and June 2025. A case was classified as confirmed when one or more pre-defined acute or habitual anal findings were documented by a certified examiner. Data were summarised using frequencies and percentages; the chi-square and Fisher exact tests were used to assess associations, with a two-sided $p < 0.05$ considered statistically significant. The study was reported in accordance with the STROBE guideline for observational studies.

Results: Of 381 examinations performed for an isolated sodomy request, 37 (9.7%) met the pre-defined criteria for a confirmed finding. Confirmed cases were more frequent in males (34/37, 91.9%) than females (3/37, 8.1%). Acute findings were documented in 27 cases (73.0%) and habitual findings in 10 cases (27.0%); all acute findings occurred in males. The most affected age group was 11–15 years (16/37, 43.2%). The difference in confirmed cases between



males and females did not reach statistical significance ($p=0.057$). The most common acute finding was an anal/perianal wound, and the most common habitual finding was a sexually transmitted infection (anogenital warts).

Conclusion: Within this referred sample, medico-legally confirmed sodomy accounted for a small proportion of examinations and was concentrated among male children aged 11–15 years. Because only cases referred to the Directorate were included, these figures describe the referred population and should not be interpreted as community prevalence. Findings are descriptive and associative; no causal inference is made.

Keywords: Sodomy; Anal penetration; Forensic medicine; Child sexual abuse; Iraq; Retrospective study.

Introduction

Sodomy is generally defined in forensic practice as anal intercourse involving at least one male, occurring with or without consent, and may be classified as homosexual (male–male) or heterosexual (male–female).^(1–3)

In Iraqi medico-legal practice, complainants are examined at the Medico-Legal Directorate after referral by the police or the judiciary, and the examiner is expected to document any physical findings objectively, to interpret them in the light of the alleged history, and to provide an opinion that can be relied upon in court. The forensic examination of living complainants is usually performed by forensic physicians, although in some settings other physicians may be assigned this role.⁽⁴⁾ Because the written report may become the principal piece of physical evidence, the quality and consistency of documentation carry considerable legal weight, and any finding must be recorded in neutral, reproducible terms.

A substantial proportion of complainants are children, who may not understand or report an assault because of shame and self-blame.^(5–8) Among adults, under-reporting remains common owing to social stigma, embarrassment, guilt, and limited awareness of legal rights.⁽⁹⁾ These factors mean that the cases reaching a medico-legal directorate represent only a fraction of those occurring in the community, and they shape the demographic profile of the cases that are ultimately examined.

Despite the medico-legal and public-health importance of sodomy, contemporary data from Iraq are limited, and most published series originate from other countries with different reporting systems and cultural contexts. Reliable local figures on how often allegations are medico-legally confirmed, on the age and sex of those affected, and on the physical findings recorded are needed to inform forensic practice, to support training, and to guide child-protection efforts. The present study was undertaken to help address this gap using the records of the Baghdad Medico-Legal Directorate over a recent two-year period.

Anal findings associated with sodomy are conventionally grouped into acute (recent) and habitual (chronic) categories, a distinction that has direct relevance for the timing and



interpretation of an alleged assault. Acute findings reflect recent trauma and include pain, tenderness, erythema, congestion, abrasions, bruising, and, in severe cases, lacerations or fissures; their presence supports a recent event but their absence does not exclude one, since the anal mucosa heals rapidly and minor injuries may resolve within days. Habitual findings reflect repeated penetration over time and include reduced anal sphincter tone, funnelling, loss of the normal radiating rugae, thickening or smoothing of the perianal skin, and sexually transmitted infections. Receptive anal intercourse is associated with an increased risk of infections including HIV, syphilis, gonorrhoea, chlamydia, herpes simplex virus, and human papillomavirus, and the identification of such an infection in a child may itself raise a medico-legal concern.^(12–14)

Review of the literature

A number of medico-legal studies from different regions have examined the frequency and pattern of sodomy and related sexual assaults, and although their settings and definitions vary, several recurring themes emerge: a predominance of male complainants in sodomy series, a concentration of cases among children and adolescents, and a recognised gap between the number of allegations and the number that are physically confirmed.

In a series from Baghdad covering 1972–1975, 24 cases showed acute findings and 45 showed habitual findings of sodomy.⁽¹⁵⁾

Sobh et al. reported that rape accounted for 56.7% of sexual-assault claims, followed by sodomy (20%), combined rape and sodomy (11.7%), intercrural intercourse (4%), and attempted rape (3%).⁽¹⁶⁾

Waheed et al. reviewed 102 sodomy cases registered at a Karachi medico-legal centre between January 2016 and December 2018, of which 99% were homosexual in nature.⁽¹⁷⁾

Küçükler analysed 268 child and adolescent victims of sexual assault (mean age 13.8 ± 2.3 years); 17.9% were male, and approximately three-quarters were younger than 15 years.⁽¹⁸⁾

Ali et al. reported that most alleged rape cases (60%) occurred in the 11–20-year age group, with a mean age of 14 ± 3 years.⁽¹⁹⁾

Aim of the study

To describe the frequency, demographic distribution, and documented physical findings of medico-legally confirmed sodomy cases referred to the Baghdad Medico-Legal Directorate during 2023–2024, and to examine their association with sex, age, type of finding, and month of presentation.

Methods

Study design and setting

This was a retrospective, single-centre study based on the examination records of the Department of Forensic Living Examination and the Clinical Management of Rape (CMR) Unit at the Medico-Legal Directorate (MLD) in Baghdad, Iraq. It covered every examination carried



out between 1 January 2023 and 31 December 2024. To remove any confusion about the timeline, the cases under study took place during 2023 and 2024; the archived records were retrieved, extracted, and analysed between January and June 2025. The study therefore deals only with the 2023–2024 caseload, and no case from 2025 was included.

Study population and eligibility criteria

Inclusion criteria: all individuals of any age and either sex referred to the MLD–CMR Unit during the study period for an examination request limited to suspected sodomy.

Exclusion criteria: examinations combining a hymen and a sodomy request were excluded from the primary analysis, in order to maintain a homogeneous denominator and to avoid double-counting of examinations performed for a different primary indication.

Case definition (operational criteria for a confirmed case)

To address the need for a standardised case definition, the following operational criteria were applied. A referral was classified as a confirmed case of sodomy when a certified forensic examiner documented one or more of the pre-defined findings listed in Table 1, recorded according to the Istanbul Protocol for the medico-legal documentation of sexual violence. Examinations in which no such finding was documented were classified as not confirmed and were not counted among confirmed cases. Where both acute and habitual findings were present, the case was assigned to the acute category for the purpose of mutually exclusive classification.

Table 1. Operational criteria used to classify a referral as a confirmed case of sodomy.

Category	Documented findings required for confirmation
Acute (recent) sodomy	Any of: anal/perianal redness, congestion, bruising, abrasion, laceration/wound, or the presence of semen.
Habitual (chronic) sodomy	Any of: reduced or absent anal sphincter reflex, funnelling, loss of rugae, smooth/silvery perianal skin, anal dilatation, or a sexually transmitted infection consistent with anal exposure.

Data sources and measurement

Examinations were performed by physicians certified in the application of the Istanbul Protocol through training delivered in collaboration with Physicians for Human Rights. Data were extracted from the MLD–CMR Unit examination reports, the Directorate archive, and the forensic photography records using a standardised extraction sheet. The variables collected were: year of examination, age (years), sex, type of finding (acute or habitual), the individual physical findings documented, the recorded relationship of the complainant to the alleged perpetrator (known/related, unknown, or not recorded), and the month of examination.



Statistical analysis

Data were entered into Microsoft Excel and analysed using standard statistical software. Categorical variables were summarised as frequencies and percentages; age was summarised using the mean and range. Associations between categorical variables (for example, sex and type of finding) were assessed using the Pearson chi-square test; the Fisher exact test was used where expected cell counts were below five. All tests were two-sided, and a p-value below 0.05 was considered statistically significant. Because several subgroups contained small numbers, p-values are reported as exact values and are interpreted with caution; a non-significant result is reported as “no statistically significant difference was detected” rather than as evidence of no difference, in keeping with the limited statistical power of the sample. Given the descriptive aim and the sample size, multivariable modelling was not undertaken; this is acknowledged as a limitation.

Ethical considerations

The study was approved by the Scientific Council of Pathology of the Iraqi Board for Medical Specializations (approval number Path 71; dated 28 July 2024) and by the Iraqi Medico-Legal Directorate, Baghdad. Because the study used existing anonymised records, the requirement for individual consent was waived by the approving committee. All data were handled confidentially and reported in aggregate, and no identifying information is presented. Given the sensitive nature of the subject, neutral clinical terminology has been used throughout, and no language implying judgement of the individuals examined has been employed.

Results

Frequency of confirmed cases

During the study period, 381 examinations were performed for an isolated request of sodomy examination. Of these, 37 (9.7%) met the pre-defined criteria for a confirmed case. The annual distribution is shown in Table 2; there was no statistically significant difference in the proportion of confirmed cases between 2023 and 2024.

Table 2. Annual distribution of confirmed sodomy cases among isolated sodomy examinations (2023–2024). Difference between years: chi-square $p=0.57$ (not significant).

Year	Examinations for isolated sodomy request	Confirmed cases (n)	Confirmed (%)	Mean age (yrs)
2023	190	20	10.5	12.2
2024	191	17	8.9	12.8
Total	381	37	9.7	12.4



Distribution by sex

Confirmed cases were more frequent in males (34/37, 91.9%) than in females (3/37, 8.1%). All female cases occurred in 2024. The difference in the distribution of confirmed cases by sex did not reach statistical significance (Table 3).

Table 3. Distribution of confirmed sodomy cases by sex (2023–2024). Association between year and sex: Fisher exact $p=0.057$ (no statistically significant difference detected).

Year	Male (n)	Male (%)	Female (n)	Female (%)	Total
2023	20	100	0	0	20
2024	14	82.4	3	17.6	17
Total	34	91.9	3	8.1	37

Type of finding (acute and habitual)

Acute findings were documented in 27 cases (73.0%) and habitual findings in 10 cases (27.0%). All 27 acute cases occurred in males. Among the 10 habitual cases, 7 were male and 3 were female. No statistically significant difference was detected across the categories (Table 4).

Table 4. Distribution of confirmed cases by type of finding and sex. All comparisons by Fisher exact test were non-significant (p-values 0.24–1.0).

Year	Male acute	Female acute	Male habitual	Female habitual
2023	16	0	4	0
2024	11	0	3	3
Total (%)	27 (73.0)	0 (0)	7 (18.9)	3 (8.1)

Age distribution

The most affected age group was 11–15 years (16/37, 43.2%), followed by those aged 10 years or younger (9/37, 24.3%). Acute findings were most frequent in the 11–15-year group, whereas habitual findings were most frequent in the 21–25-year group. No confirmed case was recorded above the age of 30 years (Table 5).

Table 5. Distribution of confirmed cases by age group and type of finding (total $n=37$).

Age (yrs)	Acute 2023	Acute 2024	Habitual 2023	Habitual 2024
≤10	5	4	0	0
11–15	8	6	2	0
16–20	2	1	0	2
21–25	0	0	2	2
26–30	1	0	0	2
Total	16	11	4	6



Distribution by month

The monthly distribution of confirmed cases across the two years is shown in Figure 1. The number of confirmed cases varied from month to month, ranging from none to a maximum of six. The highest single-month count was recorded in May (6 cases, 16.2%), and the lowest in August and October (1 case each, 2.7%); several months recorded no confirmed case at all. When the two years are viewed together, no consistent or repeating seasonal pattern is evident, and the month-to-month differences are small in absolute terms given the limited number of cases. This distribution is therefore reported as an observation only; the present data do not allow the underlying reasons for any monthly variation to be determined, and no causal explanation is offered.

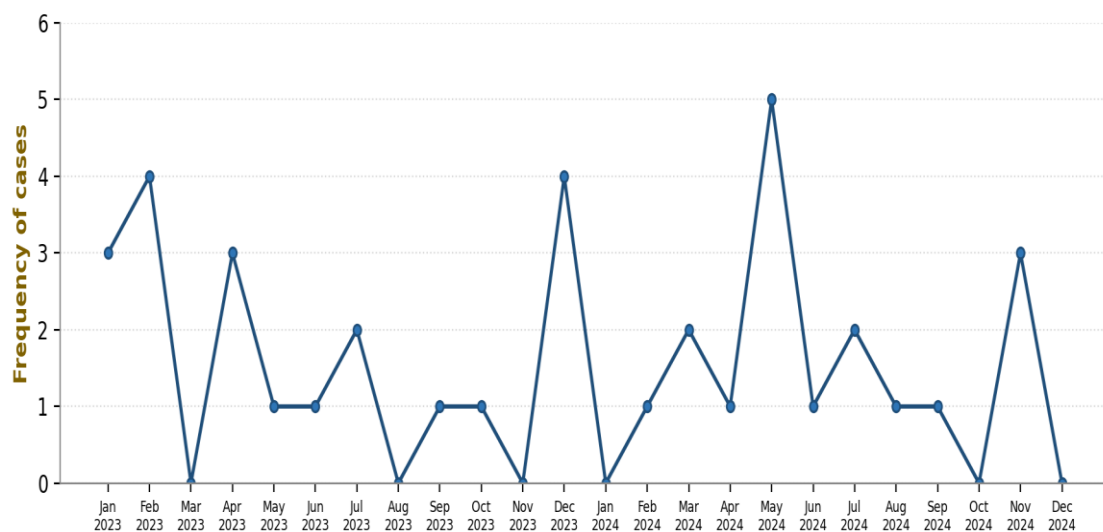


Figure 1. Month-by-month distribution of confirmed sodomy cases across 2023–2024.

Documented physical findings

The individual physical findings documented in acute cases are summarised in Figure 2. The most frequently recorded finding was an anal or perianal wound (12 cases), followed by bruising and redness (10 cases each), abrasion and congestion (5 cases each), and the presence of semen (3 cases). In a single case, faecal leakage was documented and attributed to a severe anal injury with loss of sphincter control, representing the most serious physical consequence observed in the series. Most cases showed more than one finding, with superficial signs such as redness and bruising commonly accompanying frank wounds; this clustering of findings is consistent with the pattern expected after recent forced penetration. The relative scarcity of semen reflects both the timing of examination, often days after the alleged event, and the routine use of hygiene measures before presentation.



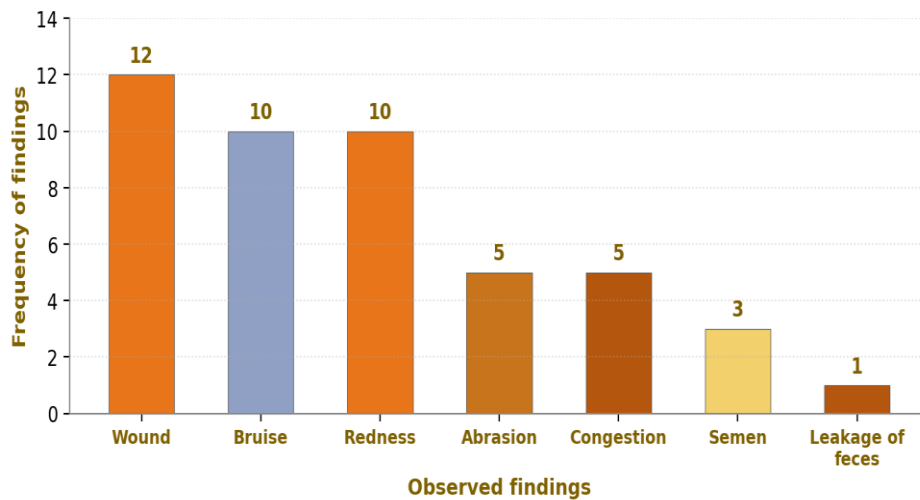


Figure 2. Frequency of documented findings in acute cases.

The findings documented in habitual cases are summarised in Figure 3. Here the most frequent finding was a sexually transmitted infection (7 cases), in every instance anogenital warts attributed to human papillomavirus and recorded alongside other chronic changes. This was followed by anal dilatation, funnelling, and reduced anal reflexes (4 cases each), loss of the normal rugae (3 cases), and a smooth or glistening perianal appearance (2 cases). The predominance of an infective finding in the habitual group is notable, since the identification of a sexually transmitted infection, particularly in a child, carries its own medico-legal significance and may be the first objective indication of repeated exposure when the structural anal changes are subtle.

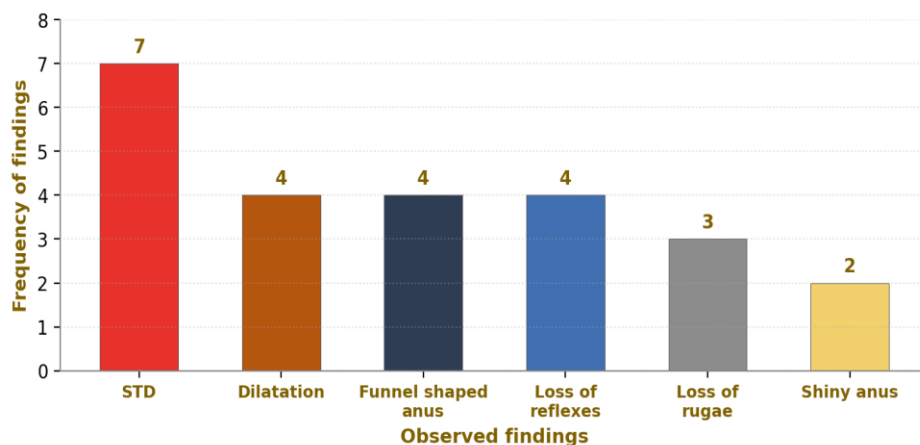


Figure 3. Frequency of documented findings in habitual cases.

Supplementary observation from combined examinations

Separately, and outside the primary analysis described above, the wider archive over the same period included 880 examinations performed for either a combined hymen-and-sodomy request



or an isolated sodomy request (549 females and 331 males). Within the combined-request subset, 4 acute and 15 habitual findings were documented. When these combined-request cases are added to the 37 confirmed isolated-request cases, the total number of confirmed findings across both referral pathways is 56. This figure is presented only as a secondary, descriptive observation; the primary denominator and all inferential analyses in this study are based on the 381 isolated-request examinations and the 37 confirmed cases, and the two figures should not be conflated.

Discussion

In this retrospective review of referrals to the Baghdad Medico-Legal Directorate during 2023–2024, 37 of 381 isolated sodomy examinations (9.7%) met the pre-defined criteria for a confirmed case. In other words, fewer than one in ten examinations performed for a suspected sodomy resulted in documented physical findings, while the majority showed no confirmatory sign. This gap between allegation and physical confirmation is widely recognised in the forensic literature and reflects several factors, including delayed presentation, the rapid healing of anal injuries, the possibility of penetration without lasting physical signs, and the entry of unsubstantiated complaints into the legal system. The proportion observed here is broadly comparable with an earlier Baghdad series and indicates that confirmed sodomy, although serious, forms a small part of the overall medico-legal workload.⁽¹⁵⁾

Confirmed cases were considerably more frequent among males than females, with males accounting for more than nine in ten cases, and all acute findings occurred in males. This male predominance is consistent with several previous reports of sodomy series, in which male complainants form the large majority.^(17,21–23) A number of explanations have been proposed for this pattern in comparable settings, including differences in the social circumstances in which boys and girls are exposed to risk and differences in the likelihood that a complaint is reported and referred; the present data, however, cannot distinguish between these possibilities. Acute findings accounted for about three-quarters of confirmed cases and habitual findings for about one-quarter, a balance similar to that described elsewhere.^(24,25) These comparisons are associative; the study design does not permit any causal interpretation, and the observed differences should be read as descriptive patterns within a referred sample rather than as population-level effects.

With respect to the recorded relationship between the complainant and the alleged perpetrator, the information available in the records was incomplete and is therefore reported descriptively only. Where documented, the pattern was broadly in keeping with previous studies, although reported rates of known versus unknown perpetrators vary considerably across settings.^(19,21,26,27)

The most affected age group was 11–15 years, followed by those aged 10 years or younger; together, children and young adolescents accounted for the great majority of confirmed cases, and no case was recorded above 30 years of age. This concentration among the young is consistent with the age distributions reported in comparable series, in which children and adolescents predominate.^(16,19,24,26) The finding underscores that, within this referred



population, sodomy is overwhelmingly a problem affecting minors, which has direct implications for child-protection services, for the way examinations of children are conducted and documented, and for the support offered to young complainants and their families.

Regarding the monthly distribution, the highest number of confirmed cases was recorded in May. This is reported as an observation only. The present data do not contain information on the circumstances surrounding each referral, and no inference can be drawn about why cases varied by month; earlier statements attributing such variation to social or cultural events have been removed, as they are not supported by the data.

The most common acute finding was an anal or perianal wound, followed by bruising, redness, abrasion, and congestion; semen was documented in a minority of cases, and one case showed faecal leakage following a severe sphincter injury, illustrating the potentially grave physical consequences of forced anal penetration. In habitual cases, sexually transmitted infection was the most frequent finding, followed by anal dilatation, funnelling, and reduced reflexes. The prominence of an infective finding in the chronic group is clinically important, because a sexually transmitted infection may persist and be detectable long after structural signs have become subtle or healed, and in a child it may provide the first objective evidence of repeated exposure. Taken together, the distribution of findings observed here is consistent with previous descriptive work and reinforces the value of combining careful inspection for structural changes with screening for infection when chronic sodomy is suspected.⁽¹⁶⁾

From a practical standpoint, these results carry several implications for medico-legal services in Baghdad. The concentration of confirmed cases among male children points to the need for examiners trained specifically in the assessment of minors and for clear, standardised documentation that can withstand legal scrutiny. The frequency with which sexually transmitted infections were identified in chronic cases supports the routine incorporation of infection screening into the examination of suspected habitual sodomy. Finally, the low rate of physical confirmation relative to the number of allegations highlights the importance of careful, non-judgemental examination and of recognising that an absence of physical findings does not exclude an assault, a point that should be communicated clearly in every report.

Limitations

Several limitations deserve emphasis. The most important is that the study covers only cases referred to the Medico-Legal Directorate by the police and the judiciary. An examination is requested only after a complaint has already entered the legal system, so the sample is subject to substantial selection bias and cannot reflect the true burden of sodomy in the community; the proportions reported here apply to the referred population alone. The number of confirmed cases ($n=37$) is also small, which limits statistical power and the extent to which the findings can be generalised, and it is the reason no multivariable analysis was attempted and potential confounders could not be assessed. Being retrospective and single-centre, the study depends on the completeness of the original records, and some variables—particularly the relationship between the complainant and the alleged perpetrator—were recorded inconsistently. Finally,



classification rested on the findings noted at the time of examination, so injuries that had healed, or that were too recent to be evident, may have been missed. The results should therefore be read as descriptive and hypothesis-generating rather than confirmatory.

Conclusions

Within this referred sample, medico-legally confirmed sodomy accounted for 9.7% of isolated sodomy examinations, with no statistically significant difference between 2023 and 2024.

Confirmed cases were more frequent in males, and all acute findings occurred in males. Habitual findings accounted for about one-quarter of cases.

The most affected age group was 11–15 years, and no confirmed case was recorded above 30 years of age.

Because only cases referred to the Directorate were studied, these figures describe the referred population and must not be read as community prevalence. The findings are descriptive and associative, and no causal conclusions are drawn. Larger, multi-centre studies with more complete documentation are needed to examine the patterns suggested here.

Declarations

Funding: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of interest: The authors declare that they have no conflict of interest.

Ethical approval: Approved by the Scientific Council of Pathology, Iraqi Board for Medical Specializations (approval number Path 71; 28 July 2024) and the Iraqi Medico-Legal Directorate, Baghdad.

Authors' contributions: Fouad Abdulhameed Qaddoori: study design, data collection, statistical analysis, and manuscript drafting. Dr. Nabeel Ghazi Hashim: critical review and editing. Both authors read and approved the final manuscript.

References

1. Biswas G. Review of Forensic Medicine and Toxicology (Including Clinical & Pathological Aspects). 3rd ed. New Delhi: Jaypee Brothers Medical Publishers; 2015. p. 388.
2. Steinberg M. Sodomy. In: The Oxford Companion to the Body. Oxford: Oxford University Press; 2001. p. 1022–3.
3. Hubbard TK. Homosexuality in Greece and Rome: A Sourcebook of Basic Documents. Berkeley: University of California Press; 2003.
4. Saukko P, Knight B. Knight's Forensic Pathology. 4th ed. Boca Raton: CRC Press, Taylor & Francis Group; 2016.
5. McElvaney R, Lateef R, Collin-Vézina D, Alaggia R, Simpson M. Bringing shame out of the shadows: identifying shame in child sexual abuse disclosure processes and implications for psychotherapy. J Interpers Violence. 2022;37(5–6):NP3404–25. doi:10.1177/08862605211037435.



6. University of Washington, Joshua Center on Child Sexual Abuse. How and when do youth disclose abuse? Seattle: University of Washington; 2022 [cited 2025 Aug 19]. Available from: <https://uwjoshuacenter.org/how-and-when-do-youth-disclose-abuse>
7. Independent Inquiry into Child Sexual Abuse (IICSA). Barriers to disclosure. London: IICSA; 2020 [cited 2025 Aug 19].
8. Bravehearts Foundation. Disclosure of child sexual abuse. Brisbane: Bravehearts; 2020 [cited 2025 Aug 19].
9. Abo-Seria M, AbdelRahman A, Mostafa H, Farag H. Study of child sexually abused cases in Cairo governorates from 2012 to 2016. *Alex J Forensic Med Clin Toxicol*. 2019;9(1):31–9. doi:10.21608/ajfm.2019.23674.
10. Loader C. Sodom and Gomorrah. In: *The Oxford Dictionary of the Bible*. Oxford: Oxford University Press; 2004.
11. The Holy Qur'an, Surah Hud (11):77–83.
12. Choudhury SR, Debnath PR, Choudhury SD. Management of anorectal injuries. *Indian J Surg*. 2015;77(Suppl 2):515–20.
13. Pathela P, Braunstein SL, Blank S, Schillinger JA. HIV incidence among men with and without sexually transmitted rectal infections. *Clin Infect Dis*. 2013;57(8):1203–9.
14. Kent CK, Chaw JK, Wong W, Liska S, Gibson S, Hubbard G, et al. Prevalence of rectal, urethral, and pharyngeal chlamydia and gonorrhoea among men who have sex with men: San Francisco, 2003. *Clin Infect Dis*. 2005;41(1):67–74.
15. Wasfi MA. *Forensic Medicine: Science and Practice*. Part 2. 5th ed. Baghdad: Al-Intisar Press; 1980. [Arabic].
16. Sobh Z, El-Banna A, Menessi H. Medico-legal assessment of physical and sexual assault allegations among adolescent and adult females referred to the Medico-Legal Department of the Ministry of Justice at Alexandria: a prospective study. *Egypt J Forensic Sci Appl Toxicol*. 2020;20(2):95–116. doi:10.21608/ejfsat.2019.14868.1086.
17. Waheed A, Talpur MGA, Khan IA, Ram H, Nezam S, Alam SP. Factors associated with sodomy cases at a tertiary care hospital of Karachi. *J Bahria Univ Med Dent Coll*. 2021;11(1):22–6. doi:10.51985/VSEL5442.
18. Küçük H. Analysis of 268 child and adolescent victims of sexual assault and the legal outcome. *Turk J Pediatr*. 2008;50(4):313–6.
19. Ali N, Akhter S, Hossain N, Khan N. Rape in rural Bangladesh. *Delta Med Coll J*. 2015;3(1):31–5.
20. Human Rights Watch. *Dignity Debased: Forced Anal Examinations in Homosexuality Prosecutions*. New York: Human Rights Watch; 2016.
21. Khater SA, Ghaleb SS, Abd Alfatah LE, Ahmad MA. Medicolegal analysis of sodomy cases in Beni-Suef Governorate from January 2011 to December 2015: a retrospective study. *Indian J Forensic Med Toxicol*. 2021;15(1):1234–41.
22. Talpur MGA, Jondhale PS, Hompe M. Magnitude of sodomy on clinical and chemical analysis. *Ann Abbasi Shaheed Hosp Karachi Med Dent Coll*. 2020;25(2):229–34.



-
23. Liautard M, Dap F, Dufour M, et al. Male victims of rape: an observational study over four years in a French university hospital. *Int J Environ Res Public Health*. 2022;19(21):13909. doi:10.3390/ijerph192113909.
24. Saleh AA. Medicolegal examination of sexual assault cases: a retrospective study. *Zagazig J Forensic Med Toxicol*. 2022;20(2):205–21.
25. Cottler-Casanova S, Lourenço V, Guillot C, Poncet A, Musse F, Imbaud R, et al. Sexual assault reporting: a retrospective study on care provided in gynaecology emergency settings after sexual assault. *Swiss Med Wkly*. 2025;155:3913. doi:10.57187/s.3913.
26. Abo-Seria M, AbdelRahman A, Mostafa H, Farag H. Study of child sexually abused cases in Cairo governorates from 2012 to 2016. *Ain Shams J Forensic Med Clin Toxicol*. 2019;32:31–9.
27. Stermac LE, Du Mont JA, Kalembo V. Comparison of sexual assaults by strangers and known assailants in an urban population of women. *CMAJ*. 1995;153(8):1089–94.

