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Sexual Offenses Against Sexual Inviolability in Türkiye: Judicial Statistics and Forensic Examination Coverage

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Abstract

Objective: In Türkiye, forensic examination of sexual assault victims is legally required to be performed by a physician, but no specific medical specialty or forensic training is mandated. In practice, it is often performed by obstetrician-gynecologists or general surgeons rather than forensic specialists. This study aimed to describe the relationship between prosecuted sexual offense cases and recorded forensic examinations and to review relevant physician training requirements.

Materials and Methods: Judicial statistics for Turkish Penal Code (TPC) Articles 102, 103, and 104, covering sexual offenses potentially requiring examination, were obtained from the Ministry of Justice's annual yearbooks for 2009–2025. Genital and anal examination counts from the Council of Forensic Medicine were obtained from the same source and were available only for 2009–2021. Prosecution and examination counts were independent aggregate datasets, not linked at the individual case level. The ratio of examinations to prosecutions was calculated descriptively for each year. Core curricula for obstetrics and gynecology, general surgery, emergency medicine, undergraduate education, and forensic medicine were reviewed.

Results: Prosecutions filed under Articles 102–104 rose from 20,566 in 2009 to 31,143 in 2019, then declined to 20,864 in 2025. The genital examination-to-prosecution ratio fell from 18.6% in 2009 to 7.1% in 2021, the last year with published data. The anal examination ratio rose from 1.8% to a peak of 14.2% in 2018, then declined to 4.7% in 2021. Neither obstetrics and gynecology nor general surgery curricula include competencies in forensic sample collection or chain of custody; emergency medicine includes related competencies only at the lowest level, whereas these competencies are addressed at the highest level in forensic medicine curricula.

Conclusion: The declining ratio suggests, but does not confirm, a growing share of examinations occurring outside the forensic medicine system. The specialties that may perform these examinations lack standardized forensic training, indicating that training is not systematically required rather than demonstrating that individual physicians lack training. Closing this gap requires structured training and dedicated response centers.

Keywords: Sexual assault, forensic examination, evidence collection, curriculum, clinical competence

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INTRODUCTION

The initial clinical encounter following a sexual assault is both a medical and a forensic event: the examining physician is responsible simultaneously for the patient's immediate care and for the accurate documentation and collection of findings that will underpin the subsequent judicial process. The integrity of this process depends on two interdependent factors, the professional conduct of the examination and its timeliness, since the opportunity to secure biological evidence diminishes rapidly with the passage of time (1). Because this evidentiary opportunity cannot be recreated once lost, the quality of the first examination effectively determines the maximum evidentiary value of the entire subsequent legal process (2).

Sexual violence against women is a global public health concern. The World Health Organization estimates that a substantial proportion of women worldwide experience non-partner sexual violence in their lifetime (3). In Türkiye, judicial statistics also reflect this burden. In 2025 alone, 76,694 case files were concluded under Articles 102–104 of the Turkish Penal Code (TPC), which address sexual offenses (4). Many of these files likely involve a clinical encounter in which a health worker was responsible for examining the victim, although not every file necessarily results in a physical examination. National research spanning more than two decades has documented the substantial psychological and social burden faced by victims following sexual assault (5).

In Türkiye, the examination of a sexual assault victim is governed by the Code of Criminal Procedure (CMK). Article 76 regulates the victim's body examination and sample collection, following the same general procedure as Article 75 for suspects (6). Article 77 adds one condition: a female victim should be examined by a female physician, if requested and where feasible (CMK Article 77). The law specifies a "physician." It does not specify a branch or forensic training requirements. In clinical practice, this gap has a direct consequence. Whichever physician is available at the institution performs the examination. Commonly, this is an obstetrician-gynecologist, a general surgeon, or an emergency physician. The examiner is selected by anatomical jurisdiction, not forensic competency. Article 102 of the TPC distinguishes the base offense from its aggravated forms, with prosecution requirements varying accordingly (7).

The national core curriculum for obstetrics and gynecology specialty training (Tıpta Uzmanlık Kurulu Müfredat Oluşturma ve Standart Belirleme Sistemi [TUKMOS]) confirms this gap. The curriculum defines competencies for genital trauma and for pediatric-adolescent sexual abuse. It defines no competencies in forensic sample collection, sample sequencing, or chain of custody in adult sexual assault cases. Forensic medicine specialists receive specific training in these areas. In practice, most cases may never reach them (8).

The present study had two aims. First, it presents a descriptive analysis of judicial statistics for TPC Articles 102, 103, and 104 in Türkiye from 2009–2025, covering sexual offenses that may involve a genital or anal examination. It compares these data with the number of forensic genital and anal examinations conducted by the Council of Forensic Medicine (CFM) over the same period. This comparison yields the ratio of forensic examinations to prosecutions filed in the same calendar year. Second, drawing on national and international literature, the study discusses what this gap means for evidentiary quality. It argues for structured forensic training for the clinicians who, in current practice, may perform most of these examinations. The design of a specific training curriculum lies beyond the scope of this study. It is addressed in separate ongoing research.

MATERIALS AND METHODS

This study has two components. The first is a descriptive, retrospective analysis of national judicial and forensic statistics. The second is a narrative review of national and international literature. No inferential or significance testing was performed. The aim is to describe patterns, not to test hypotheses about their causes.

Judicial statistics were obtained from the Ministry of Justice, Directorate General for Judicial Records and Statistics. These are published annually as *Justice Statistics* (Adalet İstatistikleri) and are available in full in the Ministry's publication archive (9). Judicial data were available for 2009–2025. Forensic examination counts were also drawn from the same yearbooks, but were available only for 2009–2021.

Articles 102, 103, and 104 of the TPC were included, together comprising the offenses that may involve a genital or anal examination and biological sample collection. Article 105 (sexual harassment) does not typically involve this process, so it was excluded. Genital and anal (livata) examination counts, as reported in the yearbooks, are not disaggregated by victim age or by the specific TPC article under which the case was prosecuted; the denominator was therefore defined at the level of these three articles combined, to match the population represented by the examination counts (10).

Genital and anal examination counts were treated as two separate series, since a single victim may receive

Table 1. Case files and forensic examination counts under TPC Articles 102–104, 2009–2025.

Year	Total case files (TPC 102+103+104)	Decision of no grounds for prosecution	Public prosecution filed	Other* decisions	CFM¥ genital examinations	CFM¥ anal examinations	Genital examination %	Anal examination %
2009	46,495	14,875	20,566	11,054	3,818	360	19	2
2010	58,617	19,778	25,265	13,574	4,877	337	19	1
2011	64,076	21,802	27,017	15,257	3,973	131	15	1
2012	66,504	22,633	28,117	15,754	4,068	475	15	2
2013	68,023	23,778	28,049	16,196	2,192	872	8	3
2014	63,653	23,833	25,252	14,568	2,344	1,474	9	6
2015	63,345	24,325	24,349	14,671	2,204	1,326	9	5
2016	56,945	22,553	20,914	13,478	1,813	1,521	9	7
2017	66,449	29,925	21,110	15,414	2,521	1,938	12	9
2018	90,925	44,299	26,419	20,207	2,881	3,763	11	14
2019	105,667	50,961	31,143	23,563	2,425	2,000	8	6
2020	84,728	41,208	24,214	19,306	1,730	1,326	7	6
2021	93,721	44,740	26,655	22,326	1,896	1,256	7	5
2022	-§	-	-	-	-	-	-	-
2023	86,276	43,132	23,694	19,450	-	-	-	-
2024	84,320	43,474	22,732	18,114	-	-	-	-
2025	76,694	40,002	20,864	15,828	-	-	-	-

* Other decisions include lack of jurisdiction, referral to another court, merger with another case file, and transfer to another unit, as categorized in the Ministry of Justice yearbooks.
CFM: Council of Forensic Medicine of Türkiye, **TPC:** Turkish Penal Code.
§ "-" sign means no available data.
Note: Genital and anal examination percentages are calculated from independent annual administrative totals (CFM examination counts and Ministry of Justice prosecution counts) and do not represent case-linked proportions.

both examinations and summing them would risk double-counting. A comparison of pre- and post-2013 *Adalet İstatistikleri* examination category lists confirmed that "genital examination" and "anal examination" were reported as continuously defined categories throughout the study period. The 2013 reporting reorganization regrouped sex-offense-related categories under a new heading and cross-referenced them to their corresponding TPC articles, without altering the definition of these two examination types.

All figures are presented descriptively. For each year, we report the total number of case files concluded under Articles 102–104, the number resulting in a public prosecution, and the corresponding counts of forensic genital and anal examinations. To assess the relationship between prosecuted cases and forensic examinations, we calculated the ratio of forensic examinations to public prosecutions for each year.

Relevant literature was identified through targeted searches of the Scite database, using terms related to each specific topic addressed in the Discussion (e.g., examiner training and forensic evidence quality, sexual assault nurse examiner (SANE) / sexual assault response team (SART) / sexual assault referral centre (SARC) models, and national judicial and forensic medicine practice). No systematic search protocol, database combination, or formal inclusion/exclusion screening was applied, consistent with the narrative, rather than systematic, nature

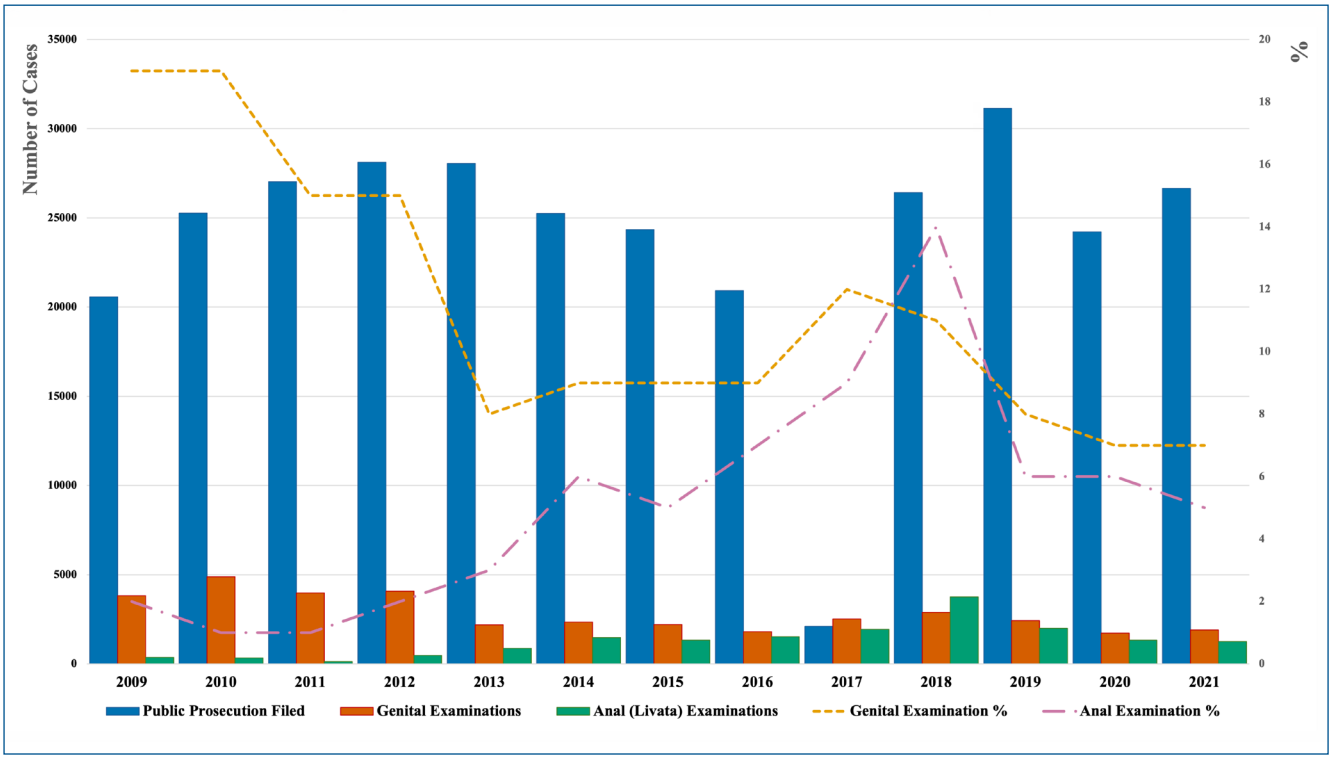

FIGURE 1. Trends in public prosecutions filed and forensic examination rates under TPC Articles 102–104, 2009–2021.

of this review component. No date restriction was applied; recency was prioritized where multiple relevant sources were available. Sources in Turkish and English were both eligible for inclusion, reflecting the study's dual national and international scope.

RESULTS

Data were obtained from the Ministry of Justice's Justice Statistics archive, covering the period from 2009 to 2025. No figures were available before 2009. Articles 102, 103, and 104 of the TPC were reported as distinct categories in every year except 2022. In 2022, only the combined total for Articles 102–105 was published, and 2022 was therefore excluded from the combined series. The combined 102–105 totals for 2021, 2022, and 2023 were 127,297; 118,959; and 118,900, respectively. These totals were 6.5% lower in 2022 than in 2021 and were nearly identical in 2022 and 2023. However, this comparison does not establish that the distribution of cases across the four articles remained stable; therefore, the combined 102–1105 total was not used to derive article-specific values for 2022. The surrounding years, 2021 and 2023, were retained in the main series.

The total number of case files concluded under Articles 102–104 rose from 46,495 in 2009 to a peak of 105,667 in 2019. It then declined, with year-to-year fluctuation, to 76,694 in 2025. The number of files resulting in a public prosecution followed a similar pattern, from 20,566 in 2009 to a peak of 31,143 in 2019, declining to 20,864 in 2025 (Table 1).

According to the figures reported in the Justice Statistics yearbooks, the CFM conducted between 1,730 and 4,877 genital examinations per year, from 2009 to 2021. There was no sustained upward or downward trend. Anal (livata) examination counts followed a different pattern. They rose from 360 in 2009 to a peak of 3,763 in 2018, then declined to 1,256 in 2021 (Table 1). Figures for both examination types were not published after 2021.

The ratios represent two independently reported annual administrative series and do not reflect case-level linkage between individual prosecutions and examinations. Accordingly, they should not be interpreted as the percentage of prosecuted victims examined by the CFM.

The ratio of genital examinations to public prosecutions fell from 18.6% in 2009 to 7.1% in 2021. The ratio of anal (livata) examinations rose from 1.8% in 2009 to a peak of 14.2% in 2018, before declining to 4.7% in 2021, as presented in Table 1 and Figure 1. Figure 1 illustrates these trends over the study period. The gap between public prosecutions filed and forensic examinations conducted persisted throughout most of the study period.

DISCUSSION

The number of case files concluded under TPC Articles 102–104 followed a fluctuating course between 2009 and 2025. It rose overall from 46,495 to 76,694 (Table 1). These articles apply to sexual assault, child sexual abuse, and sexual intercourse with a minor, respectively. Prosecution ordinarily requires a complaint. In aggravated forms of these offenses, however, a public prosecution proceeds independently of complaint. These aggravated cases are also more likely to require a genital or anal examination and the collection of biological evidence. In 2009, the number of genital examinations conducted by the CFM corresponded to 18.6% of the public prosecutions filed that year. By 2021, the last year with available forensic examination data, this ratio had fallen to 7.1%. This decline may indicate that the examination of these cases shifted, at least in part, from forensic medicine units to hospital-based units. In hospitals, this examination may be performed by a forensic medicine specialist, where one is available, or by a physician from another specialty, most commonly obstetrics and gynecology or general surgery.

This distinction matters because examiner training may affect evidence quality. A systematic review comparing forensic nurse examiners with non-specialist physicians found that examiner training was associated with more complete forensic evidence collection (11). Corum and Carroll (12) reported that forensic laboratory analysts observed higher-quality specimens from trained examiners than from untrained providers. Trained examiners were also associated with a greater likelihood that cases proceeded through prosecution (13). These findings apply to genital examination generally. They do not depend on the examiner's underlying specialty. A physician who is skilled in female pelvic anatomy is not, by that skill alone, skilled in forensic sample collection, sequencing, or chain-of-custody documentation. The two competencies are related but distinct. Non-standardized examination and documentation have also been noted to complicate subsequent forensic psychiatric evaluation in Turkish sexual assault cases (14).

An alternative, non-training-related explanation should also be considered. Law No. 6545 (2014) added a lower-severity "sarkıntılık" subtype to TPC Article 102/1. This subtype does not typically involve genital or anal examination. Its addition may have broadened the pool of public prosecutions filed under Article 102, diluting the examination ratio independently of any change in referral or examiner behavior. The available yearbook data do not permit disaggregation of this subtype from the broader Article 102 total, so this explanation cannot be quantified, but it cannot be excluded either.

Victim consent is also a relevant factor. A victim may decline a genital or anal examination even where one is clinically indicated, independent of examiner availability, specialty, or training. This factor may account for part of the observed decline but does not alter the interpretation regarding examiner training, since declined consent is unrelated to which specialty is available to conduct the examination.

National specialty training does not close this gap. The core curriculum for obstetrics and gynecology (TUKMOS) defines competencies for genital trauma and for pediatric-adolescent sexual abuse. It defines no competency for forensic sample collection, sample sequencing, or chain-of-custody procedures in adult sexual assault cases (15). A specialist trained under this curriculum is trained to diagnose and treat genital injury. Training in the forensic documentation of that injury is not part of the program. This reflects an absence of a standardized curriculum requirement, not a judgment about individual physicians' skills; some physicians may acquire relevant competence informally, through rotations, institutional protocols, or accumulated clinical experience, but this is not systematically ensured or verified. The core curriculum for general surgery shows the same pattern. It contains no reference to the management of sexual assault cases (16). Two specialties commonly tasked with this examination in practice are, by their own national training standards, not specifically prepared for it.

The core curriculum for emergency medicine differs from the other two specialties. It includes a competency labeled "evaluation of sexual abuse cases" ("cinsel istismar olgusunun değerlendirilmesi"), along with "appropriate sample collection" under a forensic matters heading. However, three qualifications apply. First, "cinsel istismar" (sexual abuse) is the terminology conventionally used for child victims in Turkish medical and legal usage, distinct from "cinsel saldırı" (sexual assault, TPC Article 102, adult victims); the competency's applicability to adult forensic examination is therefore unclear. Second, both competencies are defined at the lowest proficiency level (Level 1: knowledge of the procedure and ability to explain it, not independent performance), in contrast to competencies such as forensic record-keeping, which are defined at the highest level (Level 4: independent performance in any case). Third, the curriculum does not include chain-of-custody documentation or sample sequencing as separate, higher-level competencies. Emergency medicine training therefore acknowledges this domain in principle, but does not develop it to a level of independent clinical competency (17).

This gap in proficiency level is itself a significant finding. A physician who may be called upon to conduct a

forensic genital examination and collect legally admissible evidence is, by the curriculum's own standard, only required to reach the level of being able to explain the procedure, not to perform it independently. This mismatch between clinical responsibility in practice and the formal competency level required by training reflects the same underlying problem identified throughout this study: the absence of a forensic examination competency proportionate to the responsibility physicians actually carry.

Neither obstetrics and gynecology nor general surgery includes this training, and emergency medicine addresses it only at the lowest proficiency level. Forensic medicine specialists receive such training, but their numbers remain limited relative to national need (18). The forensic medicine core curriculum defines "sexual abuse and sexual assault cases" as a clinical competency at the highest proficiency level (independent case management), and defines sample collection, physical examination, and documentation/chain-of-custody as interventional competencies at the highest level (independent performance in any case), in clear contrast to the fragmented, low-level competencies found in the other specialties reviewed (8). One alternative exists elsewhere. Several health systems train and certify non-physician specialists specifically for this task: forensic nurses and forensic midwives. A physician typically remains involved in a supervisory role. Hands-on examination and sample collection, however, are performed by personnel trained and credentialed specifically for this purpose.

At the undergraduate level, the National Core Curriculum for Pre-Graduation Medical Education (UÇEP-2020) includes several relevant but fragmented competencies: "forensic case examination," "evidence recognition, preservation, and transfer," and "vaginal and cervical sample collection," each defined at an intermediate proficiency level (Level 2–3 of 4, corresponding to guided or routine-case performance, not independent management of complex cases). "Sexual assault" also appears as a listed topic within the curriculum's Behavioral, Social, and Human Sciences component, without a corresponding clinical or procedural competency level. No single, named competency for sexual assault forensic examination exists at the undergraduate level. These fragments provide a general foundation, but not a specific, assessable competency for this task, and they precede specialty training in any case.

The Sexual Assault Nurse Examiner (SANE) model, developed in the United States, trains registered nurses specifically in forensic examination and evidence collection for sexual assault cases (19). These SANEs typically work within a Sexual Assault Response Team (SART), a coordinated group that includes law enforcement, prosecutors, and victim advocates alongside the examiner (20). In the United Kingdom, Sexual Assault Referral Centres (SARCs) provide a parallel structure: a single site where forensic examination, medical care, and psychosocial support are delivered together, often by forensic physicians working alongside trained nurses (21). A systematic review found that trained non-physician examiners performed comparably to physicians in forensic evidence collection, with some evidence of shorter waiting times for examination (11). These models developed within legal systems that permit non-physician forensic examiners to perform this role. In Türkiye, CMK Article 76 restricts this examination to a physician. Adoption of a nurse- or midwife-led examiner model would therefore require legislative amendment; under the current legal framework, it is not achievable through training or institutional reorganization alone.

Türkiye already has a precedent for this kind of structure. The national action plan against violence against women (2016–2020) called for centers that combine statement-taking, forensic examination, and psychological support under one roof for victims of sexual violence (22). Child Monitoring Centers (ÇİM) and Violence Prevention and Monitoring Centers (ŞÖNİM) already operate on this model, for child abuse and domestic violence, respectively. The same logic applies to adult sexual assault. What is needed is not a collection of scattered examiners, each acting alone. It is a small number of standing centers, staffed continuously, where trained personnel remain in place regardless of individual turnover. This requires formal regulation. That regulation should define the qualifications of the examining personnel, the sequence of evidence collection, and the chain-of-custody procedure, as a binding national standard.

The curriculum review points to a clear training gap. Obstetrics and gynecology and general surgery do not include forensic examination and sample collection in their core curricula. Emergency medicine addresses related competencies only at the lowest proficiency level. Undergraduate training offers only fragmented, intermediate-level competencies. Forensic medicine defines this domain at the highest proficiency level, but its workforce remains too small to cover national need. The statistical trend reported above shows a possible implication of this gap: as public prosecutions filed under TPC Articles 102–104 increasingly outpaced examinations conducted within the forensic medicine system, a growing share of cases may have been examined by physicians without this specific training.

Limitations

This study has several limitations. Prosecution and examination counts were obtained from independent aggregate administrative datasets and could not be linked at the individual case level. Judicial data were not available

before 2009; the study period could not be extended to 2000, as originally intended. Forensic examination data were available only for 2009–2021; publication of these figures stopped thereafter, limiting the ratio analysis to this earlier period. For 2022, TPC Articles 102, 103, and 104 were not reported separately; only a combined total for Articles 102–105 was published. Article-specific values for 2022 could not be verified or estimated from this combined total and were therefore treated as missing. The examination and public prosecution counts used in the ratio calculation are drawn from the same calendar year, but the two events do not necessarily occur within the same year for a given case. This may introduce a structural mismatch, which cannot be quantified with the available case-level data. This study is descriptive. No inferential or significance testing was performed, and no causal claim is made regarding the observed patterns.
The judicial statistics used in this study report case files at the level of the TPC article (102–104), not at the level of the specific subsection. A more restrictive denominator limited to subsections explicitly involving penetration (e.g., TPC 102/2) could not be constructed with the available data. The "public prosecution filed" category was retained as the closest available proxy, since these cases have passed an evidentiary threshold and are more likely to involve a genital or anal examination than cases resulting in a decision of no grounds for prosecution.

The interpretation that examinations may have shifted toward hospital-based, non-forensic-medicine settings is inferential. It is drawn from the aggregate relationship between prosecution and examination counts over time, not from case-level data identifying examination location or examiner specialty. This interpretation should be read as a plausible explanation for the observed pattern, not as a confirmed finding.

Whether a single victim could be represented more than once within the same examination category (for example, through a repeat examination for the same case) cannot be verified with the aggregate data available and is not excluded.

Finally, the curriculum review reflects the formal content of national training programs. It does not directly measure individual physicians' actual clinical competence, examination quality, or chain-of-custody compliance in practice.

CONCLUSION

This study described the relationship between prosecuted sexual offense cases and forensic examination in Türkiye, and situated this pattern within the training available to the physicians who perform these examinations. The findings address both aims. The ratio of CFM-recorded genital and anal examinations to annual public prosecutions filed under TPC Articles 102–104 declined over the study period, based on independently reported annual administrative series. Whether this decline reflects an actual shift of examinations toward hospital-based, non-forensic-medicine settings is a plausible but unconfirmed interpretation, since the two datasets could not be linked at the individual case level. The core curricula of the specialties that may be responsible for these examinations in practice show an absence of explicit, standardized forensic sample collection competencies; this does not establish that practicing specialists in these fields are individually untrained, but it does indicate that such training is not systematically required or verified. Anatomical competence is not, by itself, forensic competence. Closing this gap is a matter of training and structure, not of restricting who may perform the examination.

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