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Identifying, Documenting, Investigating and Prosecuting Crimes of Sexual Torture Committed during War and Armed Conflicts, and Rehabilitation for Victims and Survivors

April 2024

Introduction

As the Special Rapporteur on Torture (SRT) call for input notes, there are multiple challenges to identifying, documenting, investigating, and prosecuting sexual torture, including when it is committed during armed conflicts. Physicians for Human Rights (PHR) has over 35 years of experience working with partners to seek accountability for this egregious form of torture against women, girls, men, boys and members of the LGBTQI community. To contribute to the Special Rapporteur's efforts to rethink and improve how these crimes are identified and addressed, in this submission, we briefly describe key good practices drawing on this experience in the following areas: 1) identification of survivors of conflict-related sexual torture (CRST); 2) effective investigation and documentation of evidence of sexual torture; and 3) achieving access to justice and accountability for survivors and successful prosecution of perpetrators. PHR is a non-governmental organization focused on improving the quality and application of the documentation of medical and psychological evidence of human rights violations to achieve accountability and justice for survivors. To complement the submissions from state and legal entities, this submission will highlight best practices to meet this aim.

PHR's proposed good practices for conflict-related sexual violence (CRSV), which may constitute sexual torture, all build on the foundation of the internationally recognized standards and principles outlined in three manuals to which PHR contributed. These manuals were developed through extensive multidisciplinary consultations and peer-reviewed evidence. These are: 1) the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol).[1] The Istanbul Protocol provides guidance for the investigation and documentation of all forms of torture, including sexual torture, and promotes the protection of torture survivors and advocacy work of civil society on behalf of survivors; 2) the International Protocol on the Documentation and Investigation of Sexual Violence in Conflict, highlighting best practices in the medical-legal evaluation of survivors of CRSV;[2] and 3) the Murad Code for Gathering and Using

[1] Office of the United Nations High Commissioner for Human Rights, "Istanbul Protocol: Manual on the Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," HR/P/PT/8/Rev. 2, 2022, https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf.

[2] Sara Ferro Ribeiro and Danaé van der Straten Ponthoz, "International Protocol on the Documentation and Investigation of Sexual Violence in Conflict: Best Practice on the Documentation of Sexual Violence as a Crime or Violation of International Law," UK Foreign & Commonwealth Office, March 2017, https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/06/report/international-protocol-on-the-documentation-and-investigation-of-sexual-violence-in-conflict/International_Protocol_2017_2nd_Edition.pdf.

Information About Systematic and Conflict-Related Sexual Violence, which focuses on cross-sectoral trauma-informed practices and survivor-centered approaches to engagement with survivors of SV.[3]

All those involved at each step of the justice process, including the identification, documentation, and prosecution of CRSV (including sexual torture), should be well-versed in and adhere to these key best-practices as baseline standards.[4]

Additional resources for guidance and standards related to documentation/investigations, medical/forensic examinations, and legal/judicial processes regarding vulnerable populations include guidance published by the World Health Organization (WHO), the Preventing Sexual Violence in Conflict Initiative (PSVI), and the National Institute for Child Health and Development (NICHD).[5]

PHR's recommended good practices also build on the critical importance of implementing trauma-informed and survivor-centered approaches in all phases that mitigate the risk of traumatizing or re-traumatizing survivors and/or subjecting them to other harms and safety issues. Additionally, it is critically important to ensure survivors provide meaningful consent to participate in the justice process, and are provided effective linkages to rehabilitation services and redress.

I. Addressing Challenges, impediments and obstacles to effective identification, documentation, investigation and prosecution of crimes of sexual torture and related ill-treatment

A. Effective systems must include multiple channels to allow for early identification of SV and referral of survivors of SV

The SRT call for input recognizes that early identification of crimes of sexual torture perpetrated in armed conflicts is often very difficult. Sexualized torture includes "verbal, emotional and physical acts of a sexual nature with the intention of producing physical and psychological suffering," as per the Istanbul Protocol.[6] Sexualized torture is a form

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[3] Nadia's Initiative, Institute for International Criminal Investigations, and United Kingdom Foreign, Commonwealth & Development Office, "Murad Code: Global Code of Conduct for Gathering and Using Information About Systematic and Conflict-Related Sexual Violence," April 13, 2022, https://static1.squarespace.com/static/5eba1018487928493de323e7/t/6255fdf29113fa3f4be3add5/1649802738451/220413_Murad_Code_EN.pdf.

[4] Vince Iacopino, Rohini J. Haar, Michele Heisler, and Rusudan Beriashvilli, "Istanbul Protocol Implementation in Central Asia: Bending the Arc of the Moral Universe," *Journal of Forensic and Legal Medicine 69*, no.101866 (January 2020), https://www.sciencedirect.com/science/article/abs/pii/S1752928X19301234.

[5] Nadia's Initiative, "Murad Code"; World Health Organization, "Guidelines for medico-legal care for victims of sexual violence," 2003, https://iris.who.int/bitstream/handle/10665/42788/924154628X.pdf?sequence=1&isAllowed=y; World Health Organization, "WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies," last accessed April 22, 2024, https://www.who.int/publications-detail-redirect/9789241595681; Ribeiro and Straten Ponthoz, "International Protocol on the Documentation and Investigation of Sexual Violence in Conflict"; Michael E. Lamb, et al., "A structured forensic interview protocol improves the quality and informativeness of investigative interviews with children: a review of research using the NICHD Investigative Interview Protocol," *Child Abuse & Neglect* 31, no. 11-12 (2007): 1201–1231, doi: 10.1016/j.chiabu.2007.03.021.

[6] OHCHR, "Istanbul Protocol," ¶ 282.

of gender-based violence. Sexual violence constitutes torture when it is intentionally inflicted on a victim by an official or with official instigation, consent or tolerance for purposes such as intimidation, coercion, punishment, eliciting information or confessions, or for any reason based on discrimination of any kind. The CEDAW Committee recognizes inter alia, rape, domestic violence, forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, and abuse and mistreatment of women and girls seeking sexual and reproductive health information as forms of sexual violence that may amount to torture or cruel, inhuman or degrading treatment depending on the circumstances.[7, 8]

As noted in the SRT call, sexualized torture includes "...such *acts or threats as forced nudity, verbal sexualized threats, sexualized degrading or humiliating mocking and other verbal or physical treatment, sexual assault by touching intimidate parts of the body, digital penetration, forced masturbation, forced insertion of an object into the vagina or anus, oral rape, anal rape and vaginal rape, ejaculation or urination onto the victim, sexual slavery, forced pregnancy and enforced sterilization*." In identifying survivors of sexual torture, it is essential to educate all stakeholders to recognize the myriad forms of sexual torture and how these may differ based on factors such as the survivor's gender, sexual orientation, gender identity, and cultural context. Moreover, the physical and verbal abuse and threats may be against the survivor, or as in the case of forced witnessing, against a family member or loved one in the survivor's presence.

Many of the barriers survivors face when reporting their experiences are the same regardless of the type of torture and cruel inhuman and degrading treatment (TCIDT) experienced. These include fear of reprisals, shame, community stigma, unawareness of processes for reporting, feeling of futility that any effective response is possible. In the case of sexualized torture, these barriers are compounded by stigma, discriminatory gender norms, fear of ostracization by one's community and possibly family, and lack of awareness that what they experienced is a prosecutable crime and violation of rights. Thus, even when the best systems are in place, there is significant underreporting of these crimes. Even when TCIDT is being investigated, survivors may not report the sexualized aspects of the TCIDT they experienced due to the factors mentioned above.

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[7] Committee on the Elimination of Discrimination against Women (CEDAW), "General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19," ¶ 16-18, U.N. Doc. CEDAW/C/GC/35 (July 26, 2017), https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Download.aspx?symbolno=CEDAW/C/GC/35&Lang=en.

[8] The Committee endorses the view of other human rights treaty bodies and special procedures mandate holders that, in determining when acts of gender-based violence against women amount to torture or cruel, inhuman or degrading treatment, a gender-sensitive approach is required to understand the level of pain and suffering experienced by women, and that the purpose and intent requirements for classifying such acts as torture are satisfied when acts or omissions are gender specific or perpetrated against a person on the basis of sex. Violations of women's sexual and reproductive health and rights, such as forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.

Unfortunately, in most countries, coordinated trusted systems and broad awareness of these systems do not exist. It is crucial to build coordinated trusted systems as a first step, to not only achieve accountability, but also to ensure that survivors have access to necessary rehabilitation services and possible reparations. It is equally important to raise broad awareness of these systems to facilitate timely identification and reporting by all possible stakeholders in the process: health professionals from whom survivors seek care, social services, law enforcement, and other stakeholders. PHR's experience shows that successful forensic documentation and accountability efforts for sexual violence and TCIDT require an enabling environment where medical and legal systems effectively work together to prioritize high-quality forensic documentation.

Important features of an enabling ecosystem for effective sexual torture investigation and documentation processes, polices, laws, and regulatory measures include:

- Development and implementation of comprehensive standard operating protocols (SOPs) that establish clear referral pathways for survivors of sexual torture (ST) and conflict-related sexual torture (CRST) to complete medical treatment and rehabilitation services. Implementation of these pathways must be accompanied by robust public information campaigns that broadly disseminate information about how and why survivors should report cases, when a forensic examination is necessary, and survivors' rights to refuse such examinations if they prefer.

- Ratification of relevant international treaties to establish state obligations with respect to sexualized torture prevention, accountability, and redress.

- Legislation to facilitate investigation and prosecution of CRST as an international crime, harmonizing the criminal code with international law on atrocity crimes, with specific reference to CRSV.

- Adequate financial and human resources. These include qualified legal and medico-legal personnel and enough health professionals with appropriate clinical qualifications, including mental health experts, and commitment to medical ethics. Ensuring such human resources usually requires sustained financial support, training, and mentorship over years.

- Strong multisectoral collaboration and active civil society participation. Efforts to create, adopt, and implement standardized operating protocols (SOPs) to achieve accountability for CRST requires cooperation among national, international, United Nations, and other multilateral organizations and non-governmental organizations. Cooperation agreements such as through memoranda of understanding (MOUs) and partnerships help to establish trust and a common understanding of challenges and actions that need to be undertaken. Such cooperation allows for a wide range of technical assistance activities,

comprehensive capacity building of relevant target groups, and monitoring of the effectiveness of implementation efforts.

- Support for the creation and/or strengthening of innovative models of holistic care and support for survivors of CRST such as "one stop centers." To better support survivors willing to seek justice, these centers provide multidisciplinary support from social workers, psychologists, lawyers trained in victim support standards and practices consistent with those laid out in international guidelines, including the Istanbul Protocol and the Murad Code, as well as approaches used by the International Criminal Court. One stop centers provide pathways through the legal process to "accompany" survivors at each step and offer referrals to medical, social, and prevention services, among other services. At all possible points of entry into the pathway for survivors, there should be protocols to integrate medical documentation obtained during survivor intake into evidentiary summaries for use in medical-legal cases.

B. There needs to be multi-sectoral capacity building in and effective systems for collection, documentation, and incorporation of forensic medical evidence in accountability processes

Fundamental to the success of established referral pathways is the need to build capacity amongst multisectoral professionals along the referral pathway for survivor-centered and trauma-informed care and support. A crucial first step is to train health professionals and legal experts in effective legal and clinical investigation and documentation practices in accordance with the Istanbul Protocol (IP) and two CRST-specific protocols and their principles. Once awareness of IP standards and partnerships among key stakeholders are created, it is necessary to build capacity on IP investigation and documentation standards. Specifically, to ensure adequate medico-legal evidence to support legal claims, we highlight several key needs.

1. All stakeholders must gain recognition of the value of forensic medical evaluations and clinical documentation in justice processes

Also known as a medical-legal evaluation, the forensic medical examination (FME) is an important aspect of any conflict-related atrocity documentation. The FME is a systematic medical and psychological evaluation of survivors of violence, including CRST. An FME involves a trained health professional collecting a narrative history from the survivor about the incident(s), performing a physical examination and documenting any scars or other injuries, performing a mental health and psychological examination and documenting psychological findings, collecting biological samples such as blood or semen as feasible, and corroborating the narrative description with the other findings. Unlike clinical encounters for the purpose of diagnosing or treating an individual, the goal of FMEs is to document and obtain narrative, physical, psychological, and possibly laboratory evidence found to corroborate the reported abuse with these findings for use in medico-legal processes.

FMEs are a critical tool for collecting evidence to corroborate accounts of sexual violence, TCIDT, and other human rights violations. Having an affidavit based on an FME can significantly increase the likelihood that survivors can obtain justice. Cases often fail due to poor quality or lack of evidence. FMEs have a significant value as part of the justice process concerning CRST even when the evaluations are conducted weeks or months after the alleged criminal acts were carried out. Often, the forensic documentation of mental health harms experienced by the survivor is the only evidence available to show the presence of ongoing trauma and other psychological injuries. FME physical and mental health documentation of CRST can provide critical evidence of perpetration and demonstrate patterns of perpetration. The demonstration of patterns may be helpful in establishing criminal intent, common purpose, command or superior responsibility, or if crimes are assessed to be widespread or systematic. CRST documentation can also be critical to document harm faced by individuals who experience sexual violence as part of a broader attack on civilians (e.g., where there is a broader attack, and sexual violence in an individual case is part of this incident), and consider what measures are necessary to promote reparation. Beyond the retributive justice process, forensic documentation has a critical role to play in a range of other accountability and justice efforts, including civil claims, reparations, and other transitional justice mechanisms.

2. Eligibility to conduct Istanbul Protocol-based medical legal examinations should be widened and training provided to non-forensic clinicians to conduct FMEs or at minimum to front-line clinicians to provide basic documentation and referrals

According to the Istanbul Protocol and evidence-based practices established globally, any licensed clinician can be trained to carry out forensic medical evaluations. The Istanbul Protocol notes, "Many clinicians including primary care physicians, psychiatrists, psychologists, clinical social workers, and nurses may acquire the knowledge and skills to diagnose psychiatric conditions. Some physicians may be able to document both physical and psychological evidence of torture or ill-treatment. Clinicians who are not formally trained in psychiatry and/or psychology may acquire knowledge and skills to identify psychological evidence of torture and ill-treatment, such as symptoms of depression, PTSD and anxiety through training or experience."[9] Similarly, WHO's guidelines for medical-legal care for victims of sexual violence explicitly states that beyond doctors and nurses with forensic training, "district medical officers, police surgeons, gynecologists, emergency room physicians and nurses, general practitioners, and mental health professionals" should be able to carry out such evaluations.[10]

In many countries, only medico-legal reports authored and signed by state-certified forensic physicians responding to an official request are acceptable as evidence in courts of law. However, the scarcity of forensic physicians presents a fundamental obstacle to a patient-centric response to sexual violence, especially when some regions mandate only board-certified forensic specialists for these evaluations. Because of shortages of locally

[9] OHCHR, "Istanbul Protocol," ¶ 308.
[10] WHO "Guidelines for medico-legal care for victims of sexual violence," 3.

recognized forensic examiners, survivors may not only face long waits in accessing trauma-focused care, but biological evidence may be lost or degraded, and physical wounds may have healed. In addition, in many settings, survivors may have to travel long distances, take time away from work or family obligations, and arrange and pay for their own transport to access a forensic medical examination. These factors create additional barriers to evidence collection and preservation, especially for those unable to afford the costs and/or are from rural areas.[11]

The dearth of forensic physicians underscores the need to involve other medical practitioners in clinical settings, particularly in frontline care settings like conflict zones, emergency departments, primary care practices, and pediatric clinics where forensic specialists are often absent. While these frontline clinicians are skilled in clinical care, they typically lack the specific forensic training required by legal standards, potentially compromising the comprehensiveness of care provided to sexual assault survivors. Academic literature and medical-legal experts emphasize the necessity of a multidisciplinary approach involving specially trained medical legal examiners to ensure survivors receive comprehensive support addressing physical, mental, social, and legal aspects of trauma. Additional training for various health care professionals is needed to enhance the collective response to sexual violence and bridge gaps in integrated care for survivors.[12]

Governments and regulatory bodies should be urged to eliminate non-evidence based restrictions to expand the pool of those capable of conducting forensic medical examinations, partner with organizations and clinicians of different specialties, and facilitate their training. Basic clinical skills and competencies are a prerequisite, along with additional specialized training on sexual violence and its clinical and mental health consequences. However, as stated in a March 2019 meeting of global IP experts in Copenhagen, Denmark, conducting medico-legal evaluations "does not require certification as a forensic expert, even though this may be the normative practice in some States and sometimes used to intentionally exclude the testimony of independent clinicians from court proceedings."

All health professionals have an absolute obligation to document and report torture and ill-treatment in all contexts under States' international legal reporting obligations and under health professionals' ethical obligations.[13] Even in settings in which non-forensic physicians can perform in-depth IP medical-legal evaluations, it is crucial to train front-

[11] Ranit Mishori, et al., "To confront sexual violence, we must train non-forensic experts to perform medico-legal evaluations." *Medical Science Law* 62, no. 2 (2022) : 149-153, https://doi.org/10.1177/00258024211029075.
[12] Ibid.
[13] General Assembly Resolution 37/194, "Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," Annex, December 18, 1982, https://ohchr.org/en/instruments-mechanisms/instruments/principles-medical-ethics-relevant-role-health-personnel; General Assembly Resolution 39/46, "Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" Article 12, December 10, 1984, https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading; World Medical Association, "WMA Statement on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment," October 18, 2022, https://www.wma.net/policies-post/wma-resolution-on-the-responsibility-of-physicians-in-the-documentation-and-denunciation-of-acts-of-torture-or-cruel-or-inhuman-or-degrading-treatment/.

line clinicians on effective referral pathways and protocols to ensure basic elements of experienced abuse are fully documented. Ideally, these clinicians should be well-trained in how to seek meaningful informed consent, a core concept of rights-based, survivor-centered, and trauma-informed practices, from the patient and be guided in effective communication strategies to inform the patient of how they can make a report or file a complaint to competent, local, national or international entities for further investigation.[14]

Even within the limitation of brief clinic visits (less than 15 minutes in many contexts), it is critically important that clinicians receive training in several key areas. The first is in the identification of different methods of CRST and their potential sequelae. The second is in the assessment and documentation of signs and symptoms of torture or ill-treatment in medical records, including correlation between the alleged abuse and the clinical findings. Such high-quality medical documentation can then effectively be used as evidence in later legal or administrative proceedings or used as a foundation for a more in-depth IP evaluation by an IP-trained clinician.

Again, while clinicians can provide basic documentation, it is essential to have clear referral pathways for a more in-depth forensic exam. A holistic, survivor-centered approach for survivors of atrocity crimes must include reliable and accessible referral pathways to medical and psychological care, legal aid, other psycho-social support, and reporting to authorities if desired.

Increasing the number of clinicians who can conduct both in-depth IP medical-legal evaluations and those who can provide basic documentation in clinical settings will require time, effort, and funding. Governments and international organizations must commit the necessary resources to provide training and develop standardized quality metrics and competency assessments. It is also important to provide booster support and ongoing mentorship until clinicians reach recognized proficiency standards of documentation and, in the case of full IP evaluations, report writing.

3. Clinicians must have and use peer-reviewed, standardized forms and protocols to facilitate their documentation

Along with training, clinicians need standardized documentation tools and procedures, including standardized medico-legal certificates for forensic examinations, to ensure that evidence collected from survivors of CRST can be used for justice processes. Standardized documentation of sexual violence has been shown to lead to better adjudication outcomes for survivors.[15] Use of standardized protocols for interviewing

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[14] Christian De Vos, et. al, "Torture beyond carceral settings against individuals from marginalized communities: the important role for clinical documentation," *Torture Journal* 33, no. 2 (2023), https://doi.org/10.7146/torture.v33i2.135272.

[15] Rachel Jewkes et al., "Medico-Legal Findings, Legal Case Progression, and Outcomes in South African Rape Cases: Retrospective Review," *PLOS Medicine* 6, no. 10 (2009), doi: 10.1371/journal.pmed.1000164; Margaret J. McGregor, Janice Du Mont, Terri L. Myher, "Sexual assault forensic medical examination: is evidence related to successful prosecution?," *Annals of Emergency Medicine* 39, no. 6 (2002); 639-647, doi: 10.1067/mem.2002.123694; Kelly

and examining survivors (such as the Istanbul Protocol) should be key tools to enhance the quality, comprehensiveness and accuracy of evidence collected on CRST. These standardized documentation tools and collection procedures are crucially important to ground practices in trauma-informed principles and to ensure the quality of evidence collected. Standardization allows for more survivor-centered care by reducing the number of times a survivor must repeat the story of their assault.[16] The benefits of protocols not only contribute to better patient care, but may also increase the possibility of matching a victim's genetic material to a perpetrator,[17] and thus, to achieving justice for the survivor.[18]

With medical and legal partners in eastern DRC, PHR created a standardized forensic medical intake form – the medical certificate – used by clinicians to document medical and psychological findings during evaluations and to capture standardized data that can inform police investigations and prosecutions. Clinicians in PHR's extensive networks are able to produce court-admissible evidence using the medical certificate. The medical certificate is featured as a model form in the landmark *International Protocol on the Documentation and Investigation of Sexual Violence in Conflict*, a document we contributed to in 2014 and helped revise in 2017.[19] The medical certificate's standardized format allows for a wide variety of trained clinicians—including clinical officers, nurses, and non-forensic doctors— to consistently document court admissible forensic medical findings in a wide variety of clinical settings. In 2023, PHR achieved a significant victory when the medical certificate was adopted at the national level as the standardized medical intake form in DRC, showing the potential of integrating standardized documentation tools within resource challenged public health systems.[20]

Building on the success of our multisectoral training approach and lessons learned in DRC and Kenya, PHR has worked since 2017 to equip a multisectoral network of professionals responding to torture and sexual violence in Iraq, especially for the Yazidis and other minorities in northern Iraq. PHR has since trained clinicians, investigators, lawyers, and judges to collect, document, and interpret forensic evidence of sexual violence using the Istanbul Protocol and the International Protocol on the Documentation and Investigation of Sexual Violence in Conflict. As a result of this work with national partners, we developed a forensic medical form for documenting forensic

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Gray-Eurom et al., "The prosecution of sexual assault cases: correlation with forensic evidence," *Annals of Emergency Medicine* 39, no. 1 (2002): 39-46, doi: 10.1067/mem.2002.118013; Mette Louise B. G. Kjærulff et al., "The significance of the forensic clinical examination on the judicial assessment of rape complaints - developments and trends," *Forensic Science International* 297 (2019): 90–99, https://doi.org/10.1016/j.forsciint.2019.01.031.

[16] Marco Bo, et al., "Violence against pregnant women in the experience of the rape centre of Turin: Clinical and forensic evaluation," Journal Forensic and Legal Medicine 76, no. 102071 (November 2020), doi: 10.1016/j.jflm.2020.102071.

[17] Sarah Gino, et al., "Evaluation of critical aspects in clinical and forensic management of sexual violence: A multicentre Ge.F.I. project," *Forensic Science International* 314, no. 110387 (September 2020), doi: 10.1016/j.forsciint.2020.110387.

[18] Christine Gilles, et al., "Implementation of a protocol and staff educational sessions improves the care of survivors of sexual assault," *Maturitas* 124 (2019): 39-42. https://doi.org/10.1016/j.maturitas.2019.03.004

[19] Ribeiro and Straten Ponthoz, "International Protocol on the Documentation and Investigation of Sexual Violence in Conflict," xix.

[20] Physicians for Human Rights, "Certificat médico-légal d'agression sexuelle : Conseils pratiques," accessed April 22, 2024, https://phr.org/wp-content/uploads/2019/11/Medical-Certificate-Companion-Guide-DRC-French-.pdf.

evidence that meets international standards and will play a vital role in ensuring survivors' access to an equitable and evidence-based forensic documentation process. In working with Iraqi forensic institutions, we support a growing network of professionals that understand the value of forensic medical evidence, know how to minimize survivor retraumatization, and are capable of collaborating across sectors to support justice for survivors.

Some practical evidence of success can be found in the Kavumu case in the Democratic Republic of the Congo. In that case, a local court convicted 11 men, including a sitting member of parliament, of crimes against humanity for raping dozens of young girls. The doctors and nurses at Panzi General Reference Hospital in Bukavu who treated the patients were not forensic specialists, but they were trained by PHR to conduct comprehensive forensic evaluations on sexual violence survivors and were able to effectively capture, document, and preserve forensic medical evidence. This compelling medical evidence played an important role in informing the judgment.[21]

4. Effective digital tools are useful to facilitate standardized clinical documentation

As noted earlier, too often efforts to prosecute perpetrators of torture fail in the courts due to inadequate or missing evidence. To complement training and the development of appropriate standardized protocols and forensic documentation forms, it is useful for clinicians to have easy-to-use digital tools for documentation. One digital solution is PHR's mobile application for forensic documentation—MediCapt, which is now being implemented in Kenya and DRC.

This award-winning app makes it possible to capture reliable and secure documentation of forensic evidence necessary to support sexual violence cases. MediCapt provides a digital platform to facilitate the complete collection of evidence, including forensic photography of injuries sustained by victims of torture and sexual violence, in conformity with Istanbul Protocol norms. MediCapt also allows forensic evidence to be securely shared with multisectoral professionals, including in law enforcement, and improves access to justice for survivors of torture.

MediCapt, co-created with partners in the Democratic Republic of the Congo (DRC) and Kenya, can be used by medical professionals to collect, securely store, and safely share forensic medical evidence with legal and law enforcement officials in sexual violence cases while maintaining chain of custody, safeguarding patient privacy, protecting witness identities, and preventing destruction or loss of vital information.

The app was developed on the assumption that increasing the quantity, improving the quality, and ensuring the security and integrity of forensic medical evidence would support effective investigations and prosecutions of sexual violence crimes. The app converts a standardized medical intake form used for forensic documentation to a

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[21] Karen Naimer, Muriel Volpellier, and Denis Mukwege, "The case of kavumu: a model of medicolegal collaboration," *Lancet* 393, no. 10191 (2019): 2651-2654, doi: 10.1016/S0140-6736(19)30649-X.

digital platform and combines it with a secure mobile camera to facilitate forensic photography. By combining these components, MediCapt can preserve critical forensic medical evidence of atrocities, including sexual violence, for use in courts. Once digitized, these forms can be analyzed to discern patterns of perpetration and harm, providing critical evidence for accountability and justice.

The app prevents the loss of collected evidence by taking a forensic photograph directly through the application and saving this data in the cloud, subverting any possible efforts to tamper with evidence or the chain of custody. To date, MediCapt has been piloted successfully in one facility in the DRC and three facilities in Kenya. MediCapt has standardized and improved the quality of information collected compared to the paper-based form. Furthermore, MediCapt introduced new features that enhanced the quality of evidence collected and the survivor-centered nature of the process, while increasing the accuracy and efficiency of forensic documentation. Our published report provides evidence of the effectiveness of MediCapt, and our article in the journal Global Health Science and Practice discusses the process PHR used to collaboratively design and develop MediCapt with clinicians in Kenya and the DRC.[22]

Another relevant technological innovation is ViVoMo, a voice modification system developed by PHR that empowers and protects victims and witnesses of sexual violence by allowing them to testify without being identified by the defendants, witnesses, or members of the public.[23] This good practice was used successfully in the Kavumu case in the DRC to allow witnesses to testify in mobile trials happening in their communities.

5. It is essential to avoid some common misconceptions around forensic evidence

i. DNA evidence is not essential

DNA technology in sexual violence cases can strengthen investigations and prosecutions, but training on how to collect and preserve evidence is equally important and is lacking worldwide.[24]

DNA technology in sexual violence cases has indeed strengthened investigations and prosecutions. The technology allows police to collect a wider range of compelling evidence, and DNA may also connect a suspect to a crime scene. But specimens are only meaningful when they can be matched with a reference sample – which means that the

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[22] Physicians for Human Rights and Naivasha County Referral Hospital, Nakuru, "Using MediCapt to Document Medical Evidence of Sexual Violence in Kenya: Perspectives from the End Users," November 2019, https://phr.org/wp-content/uploads/2019/11/Using-MediCapt-to-Document-Medical-Evidence-of-Sexual-Violence-in-Kenya-Perspectives-from-the-End-Users.pdf; Ranit Mishori, et al., "mJustice: Preliminary Development of a Mobile App for Medical-Forensic Documentation of Sexual Violence in Low-Resource Environments and Conflict Zones," *Global Health: Science and Practice* 5, no. 1 (March 28, 2017): 138-151. doi: 10.9745/GHSP-D-16-00233.
[23] Physicians for Human Rights, "PHR's ViVoMo Voice Modification System," accessed April 22, 2024, https://phr.org/wp-content/uploads/2020/04/ViVoMo-Fact-Sheet_FINAL_ENGLISH_2.pdf.
[24] Karen Naimer, "DNA testing can help – and hinder – sexual violence prosecutions," Open Global Rights, February 28, 2018. https://www.openglobalrights.org/DNA-testing-can-help-and-hinder-sexual-violence-prosecutions/.

suspect must have already been identified. This makes DNA evidence less relevant in cases of gang rape or conflict-related violence, where perpetrators are often unknown. While DNA evidence can be helpful to link a perpetrator to an act, DNA evidence cannot establish whether sexual contact was consensual, which is why it is critical that other forms of evidence are also gathered regardless of the absence of presence of DNA evidence. Further, in many instances, biological specimens cannot be produced, for example, if the perpetrator used a condom, or if the survivor bathed after the assault or did not visit a clinic until several days afterward.

A survivor should not be denied access to justice when there is no DNA evidence. The absence of DNA does not mean the crime did not occur, just as its presence should not lead a judge to conclude a crime did occur. Several studies on sexual assault show that most victims do not report to health care facilities within three or four days of an attack, the optimal time to collect biological evidence.[25] Moroever, in parts of central and eastern Africa, transportation to health clinics can be difficult – in the Democratic Republic of the Congo, for example, poor roads, expensive fuel, and lack of access to vehicle force survivors in rural areas to walk for several days to get treatment. Furthermore, most health care providers in less developed regions have not been trained in collecting biological specimens, such as DNA, nor do they have the resources to adequately do so. Health care facilities in rural areas of even middle-income countries typically have limited or no access to rape kits. For those that do, many victims cannot afford the cost if personally charged for the DNA lab analysis.

Thus, in many countries in which there is CRST, it is more important to prioritize rigorous training in core competencies over investing in complex and often expensive technology; DNA evidence should never be required to prove that rape took place. It should instead be viewed as one more tool in advancing justice for victims of sexual violence.

ii. Psychological evidence—even if there is no physical evidence—is critically important evidence of CRST

All stakeholders need to receive training and be made aware that psychological harms may be the only evidence of CRST. This recognition must also be enshrined in relevant laws and policies. For example, forced nudity may not result in physical injury to a survivor, but international law recognizes this as a form of sexual violence. Moreover, most physical effects of CRST often disappear within days and weeks, with psychological harms remaining for years or forever.

iii. Hymen assessments do not provide probative evidence

The hymen is a small membranous tissue with no known biological function, which typically occupies a portion of the external vaginal opening. Testing usually involves

[25] Antonia Quadara, "The role of forensic medical evidence in the prosecution of adult sexual assault," Australian Institute of Family Studies, accessed April 22, 2024, https://aifs.gov.au/resources/practice-guides/role-forensic-medical-evidence-prosecution-adult-sexual-assault.

visual inspection of the hymenal membrane by a medical professional (physician, nurse or midwife). In some cases, the examination includes a 'two-finger' test to assess the size of the vaginal opening.

An examination of the hymen is not an accurate or reliable test of sexual activity, including sexual assault with forced penetration, except in very specific situations. In most cases, there is no correlation between a hymen's appearance and the reported history of prior sexual intercourse. An examination of the hymen cannot accurately or reliably tell you whether a woman has had intercourse.[26] Even in children with suspected sexual abuse, the majority will have normal or nonspecific findings. Unless there are extensive laceration(s), hymenal injuries heal rapidly and usually leave no evidence of any previous injury. A significant body of scientific evidence demonstrates that the vast majority of children who have been sexually abused, including with vaginal and anal penetration, have normal ano-genital examinations.[27] Clinicians who perform forensic sexual assault examinations should thus avoid descriptions such as "intact hymen" or "broken hymen" in all cases and describe specific clinical findings using specific medical terminology.

Despite the lack of specificity and sensitivity, where sexual assault or abuse is alleged, a full forensic examination of the child or adult is still imperative. Information gleaned from a forensic assessment that includes an ano-genital examination can support a legal charge of various forms of sexual violence. However, it is important to note that several types of forensic evidence are needed to support a legal charge, including patient history, physical evidence (e.g. injuries to the genital and non-genital regions of the body), psychological evidence, laboratory evidence (e.g. spermatozoa, DNA, and sexually transmitted organisms), or other forms of forensic physical evidence. During the physical examination, the hymen tissue may or may not be present, or be present with or without abnormalities, depending on the patient's age, history, and other factors.

iv. Anal examinations may be necessary in documenting CRST but should not be misused

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[26] Sondra S Crosby, Nicolette Oleng, Muriel M Volpellier, Ranit Mishori, "Virginity testing: recommendations for primary care physicians in Europe and North America," *BMJ Global Health* 5 (2020), doi:10.1136/bmjgh-2019-002057; Ranit Mishori, et al., "The little tissue that couldn't – dispelling myths about the Hymen's role in determining sexual history and assault," *Reproductive Health* 16, no. 74 (June 3, 2019), https://doi.org/10.1186/s12978-019-0731-8.

[27] Astrid H. Heger, "Appearance of the genitalia in girls selected for nonabuse: review of hymenal morphology and nonspecific findings," *Journal Pediatric & Adolescent Gynecology* 15, no. 1 (2002): 27–35, doi: https://doi.org/10.1016/S1083-3188(01)00136-X; John McCann, "Perianal findings in prepubertal children selected for nonabuse: A descriptive study" *Child Abuse & Neglect* 13, no. 2 (1989): 179-193, https://doi.org/10.1016/0145-2134(89)90005-7; Muriel Volpellier, "Physical forensic signs of sexual torture in children. A guideline for non specialized medical examiners," *Torture Journal* 19, no. 2 (2009): 157-176, https://pubmed.ncbi.nlm.nih.gov/19920333/; John McCann, "Healing of Hymenal Injuries in Prepubertal and Adolescent Girls: A Descriptive Study," *Pediatrics* 119, no. 5 (May 2007), https://publications.aap.org/pediatrics/article-abstract/119/5/e1094/70206/Healing-of-Hymenal-Injuries-in-Prepubertal-and?redirectedFrom=fulltext.

The practice of forcibly conducting anal examinations in countries where consensual anal intercourse is criminalized is highly discriminatory and lacks medical or scientific validity in determining sexual activity. Typically performed on males to "prove" homosexuality, these exams cause significant physical and psychological harm without yielding relevant evidence. Such examinations are deemed as cruel, inhuman, and potentially tantamount to torture, particularly when involving anal penetration.[28] Involvement of health professionals in these procedures violates ethical standards and may constitute sexual assault and rape.[29] Forensic examinations should not become venues for sexualized torture.

v. It is also important not to rely excessively on FMEs

It is also important to reinforce that when it is not possible to secure an FME, a strong case for CRSV can still be made. As the International Protocol declares: "In international criminal practice, the use of medico-legal evidence to prove CRST is not necessary. Such a requirement would impose an impossible barrier to justice for the majority of victims who do not have access to medical services close to the time the sexual violence had been perpetrated. This is true in particular in cases where the sexual violence has been perpetrated in the context of detention or forcible displacement, sexual slavery, and where ongoing violence makes mobility and access to health services impossible." While FMEs are helpful when possible and can play an important part of an investigation, their absence should not be an obstacle for survivors, prosecutors, investigators, and judges to proceed with a case.[30]

C. Effective coordination and collaboration among health care, police, legal sectors are essential for effective investigations and prosecution

A crucial prerequisite for implementing survivor-centered referral pathways is to conduct multisectoral trainings, including on forensic examination, with the goal of strengthening collaboration, coordination, and capacity to effectively collect and interpret forensic evidence, interview survivors of CRSV, and ensure chain of custody. Relevant stakeholders need a shared understanding of their roles in forensic documentation and familiarity with basic definitions, principles, and protocols.

PHR has a proven track record bringing medical, law enforcement, and legal professionals together to gather and preserve forensic medical evidence of CRSV and torture and cruel, inhuman, and degrading treatment (TCIDT) in a survivor-centered and trauma-informed manner to support accountability processes. PHR's Multisectoral Training on the Collection, Documentation, and Use of Forensic Evidence of Sexual Violence aspires to enhance the capacity and cultivate collaboration of national medical,

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[28] Physicians for Human Rights, "Statement on Anal Examinations in Cases of Alleged Homosexuality," May 1, 2016, https://phr.org/our-work/resources/statement-on-anal-examinations-in-cases-of-alleged-homosexuality/.
[29] Independent Forensic Expert Group, "Statement on Anal Examinations in Cases of Alleged Homosexuality," accessed April 22, 2024, https://s3.amazonaws.com/PHR_other/statement-on-anal-examinations-in-cases-of-alleged-homosexuality.pdf.
[30] Ribeiro and Straten Ponthoz, "International Protocol on the Documentation and Investigation of Sexual Violence in Conflict," 158.

law enforcement, and legal professionals. The trainings highlight the importance of the multisectoral response to sexual violence, and build skills to carry out forensic medical evaluations and interviewing techniques, evidence collection, and the presentation of evidence in trial, among other areas.

PHR's training is an evidence-based approach that independent evaluations have shown can (a) improve coordination among sectors, (b) enhance survivor-centered care, (c) increase standardization of forensic practices within medical, legal, and law enforcement communities, and (d) result in higher quality evidence collection. Training participants in the Democratic Republic of the Congo and Kenya have demonstrated increases in forensic knowledge after exposure to PHR's multisectoral trainings. For example, an article about our work in Kenya was published in August 2022 in the journal *Violence Against Women*, finding that scaling medico-legal training and strengthening multisectoral networks in areas with high rates of SGBV are promising strategies for increasing collaboration, enhancing the quality of services, and improving justice processes for survivors of SGBV. In Iraq, PHR has worked for the past six years to strengthen the capacities of the legal, judicial, and medical sectors to document, analyze and preserve evidence of torture and sexual violence crimes, including conducting trainings for clinicians. Those approaches led to a growing recognition among professionals in these different sectors about the importance of standardizing the forensic medical form to ensure consistency and accuracy in documenting forensic evidence. Also, it led to a multisectoral consensus on the importance of respecting human rights principles when conducting forensic documentation. This includes obtaining informed consent, assent, and dissent from individuals undergoing forensic examinations, regardless of the legal or judicial status of the case.

Case from Kavumu

Through multisectoral partnerships, PHR professionals and partners helped achieve justice for survivors of sexual violence by helping bring cases to trial. One notable example of this was in the South Kivu village of Kavumu in the DRC. In 2013, more than 40 young girls, some as young as 18 months old, were kidnapped from their homes, raped, and then left in the fields surrounding Kavumu. To support the girls and their families in the fight for justice, PHR worked with multisectoral professionals to gather forensic evidence from the survivors, coordinate the investigation, and provide technical assistance to professionals. This work was integral for the eventual conviction in December 2017 of the perpetrators, including Frederic Batumike, a regional legislator in DRC, and 10 other militia members. They were found guilty of crimes against humanity by rape and murder and sentenced to life in prison.

A multisectoral network convened by civil society organizations from Kavumu, local clinicians, police officers, and NGOs ensured that the girls and their familiars were kept informed at each stage of the legal process and frank conversations were held around security concerns, which were particularly acute in this case. Their feedback was integrated into the monthly meetings and mitigation measures were taken by partners, such as providing training and support on how to enhance their protection.

Through these efforts, the mobile military court adopted several aspects of a trauma-informed participation strategy, including allowing recordings of the children's testimony instead of requiring they be questioned in open court. Witnesses appeared in court identified only by coded pseudonyms; they stood behind a protective screen, used a special voice modification device, and were covered from head to toe in fabric to shield their identities from the public.

States that are committed to ending torture and ill treatment, including CRST, must facilitate engagement and demonstrate cooperation with civil society organizations, movements, professional organizations, and leaders on anti-torture actions. States should encourage and support a national network of non-governmental medico-legal experts to conduct clinical evaluations of alleged torture, review the quality and accuracy of state evaluations, and participate in policy reform, capacity building, and public education activities. States should also ensure that non-state legal and clinical actors have access to all relevant information, such as case files and investigations, in medico-legal cases of alleged torture as well as deaths in custody.

International and national entities should continue to focus on strengthening the capacity of medical, legal, and judicial sectors and civil society organizations, especially survivor-led organizations. Multisectoral collaboration is key to understanding the aspects of science, medical documentation, and psychological evidence in court and is essential to establishing safeguards to prevent torture and ill treatment.

D. It is imperative to integrate rehabilitation and trauma-informed approaches and ensure survivor participation to reinforce a justice-oriented response

A trauma-informed approach is founded on the principles of safety, trust, transparency, peer support, collaboration, and mutuality of all engaged actors. Effective approaches seek both to empower survivors and ensure their active participation and choices. Trauma-informed approaches are further based on a foundational recognition of the importance of cultural, historical and gender issues.

In the context of legal accountability, all stakeholders (e.g., interviewers, investigators, prosecutors, judges, defense counsel, etc.) should anticipate the presence of trauma in all affected individuals. Stakeholders should be trained to avoid replicating or compounding trauma (re-traumatization), and should understand that trauma may affect survivors' and witnesses' feelings, behaviors, ability to recall and engage meaningfully with the proceedings, as well as impact rehabilitation at the conclusion of legal proceedings. A trauma-informed lens must be applied in all stages and phases of the justice process, including investigation, interviewing, physical examination, communication, courtroom procedures, witness testimonies, perpetrator questioning, safety assessment, sentencing, and post-sentencing follow-ups and referrals, as well as redress mechanisms.

Moreover, the principle of inclusion emphasizes a process that ensures individuals from diverse and marginalized backgrounds – including children – are integrated into and are central to the development of policies, activities, and programs.

A trauma-informed approach requires a comprehensive assessment that can serve as the basis for an individualized management plan for each survivor or witness. It should also consider the trauma responses that may be experienced by all engaged staff and experts (vicarious trauma). A stakeholder using trauma-informed practices should communicate effectively and emphatically with affected individuals and consider eliminating or modifying court procedures that could be perceived as threatening and adjust the physical environment to create a more welcoming setting that enhances a survivor's sense of safety.

Good practices that incorporate trauma-informed principles include: [31]

(a) using a comprehensive vulnerability assessment that would serve as the basis for an individualized management plan for each survivor or witness;
(b) ensuring referral pathways are available for survivors to access mental health services before, during, and after participating in an interview;
(c) utilizing a multidisciplinary team to support survivors with disclosure, documentation, and support;
(d) embedding a psychologist within an investigation team to ensure continual assessment and adjustment of the trauma informed approach;
(e) when psychologists are not accessible, provide training to clinicians on the fundamentals of conducting mental health screenings using internationally validated scales;
(f) creating a glossary of culturally appropriate terms and idioms that can be used by investigators and judges to support victim and witness testimony;
(g) considering and developing programs to address the vicarious trauma of staff and experts working on cases;
(h) creating and using standard operating procedures (SOPs) to train staff to communicate effectively and empathetically with affected individuals;
(i) eliminating or modifying judicial or court procedures that could be perceived as intimidating or threatening;
(j) adjusting the physical environment to create a more welcoming setting and enhance the sense of safety; and
(k) creating processes that address and respond to occupational vicarious trauma.

[31] Physicians for Human Rights and Cardozo Law Institute in Holocaust and Human Rights, "Submission from Physicians for Human Rights and the Cardozo Law Institute in Holocaust and Human Rights following the call for comments by the Prosecutor for the International Criminal Court regarding the 2016 Office of the Prosecutor's Policy on Children," May 30, 2023, https://phr.org/wp-content/uploads/2023/06/ICC-OTP-Submission_PHR-Cardozo_May-2023.pdf.