

# Problematic of Medical Expert Requisition in Cases of Interpersonal Violence: An Empirical Study at the Public Prosecutor's Office of Mukaza, Bujumbura, Burundi

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## Abstract

## Original Research Article

Medical expert requisition constitutes a cornerstone of evidence collection in criminal proceedings involving interpersonal violence. In Burundi, despite the legal obligation mandated by the Code of Criminal Procedure and the Law on Gender-Based Violence (Law No. 1/13 of September 22, 2016), the practical implementation of expert requisition remains fraught with procedural, technical, and institutional challenges. Objective: This study empirically examines the problematic dimensions of medical expert requisition in interpersonal violence cases at the Mukaza Public Prosecutor's Office in Bujumbura, Burundi, with a view to documenting challenges and formulating evidence-based recommendations. Methods: A mixed-methods approach was employed combining quantitative data from 186 judicial case files and qualitative data from semi-structured interviews with 60 magistrates, judicial police officers, and medical experts. Yamane's formula (1967) was applied to determine the sample from a population of 207 stakeholders. Results: Findings reveal significant deficiencies including improper formulation of expert requisitions (67.2%), absence of forensic psychology expertise (100%), inadequate expert honoraria regulation (82.8%), shortage of forensic medicine specialists (74.7%), and delayed expertise production (78.5%). Discussion: These results are consistent with comparative studies from Sub-Saharan African jurisdictions and international literature documenting systemic weaknesses in medico-legal systems in developing legal contexts. Conclusion: Urgent structural reforms are required including standardization of requisition forms, continuous training programs for judicial and medical actors.

**Keywords:** medical expert requisition, interpersonal violence, forensic medicine, judicial procedure, Burundi, gender-based violence, criminal evidence.

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## INTRODUCTION

Violence in its manifold expressions represents one of the most persistent threats to human dignity, social cohesion, and public health across all societies and historical epochs (Krug *et al.*, 2002, p. 3). The World Health Organization defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation' (WHO, 2002, p. 4). This definition captures the multidimensional nature of violence and underscores the imperative for robust institutional responses at the legal, medical, and social levels. Interpersonal violence, as a subcategory of this broader phenomenon, encompasses acts of violence committed between individuals who are known to each other or strangers, and includes physical assault, sexual

violence, domestic violence, and homicide (Dahlberg & Krug, 2002, p. 89). According to the WHO Global Status Report on Violence Prevention, approximately 1.6 million people lose their lives annually as a direct result of interpersonal violence, making it one of the leading causes of death globally for individuals between the ages of 15 and 44 (WHO, 2014, p. 12). Beyond mortality, interpersonal violence generates substantial morbidity, generating long-term physical and psychological sequelae that impose enormous burdens on individuals, communities, and health systems (Krug *et al.*, 2002, p. 17).

Within the framework of criminal justice, the adjudication of interpersonal violence cases depends fundamentally on the quality and admissibility of evidence (Moenssens *et al.*, 2008, p. 45). Among the various evidentiary tools available to prosecutors and

judges, medical expert evidence occupies a particularly privileged position given its capacity to establish the nature and extent of injuries, determine causal links between the violent act and the resulting harm, and provide objective scientific underpinning for judicial decision-making (Saks & Koehler, 2005, p. 892). As Champod and Vuille (2011, p. 152) observe, forensic evidence provides the courts with a 'bridge between the scientific and legal domains' that is indispensable in adjudicating cases where direct testimony may be compromised by fear, trauma, or social pressure.

The role of the medical expert in criminal proceedings has evolved considerably over the past century, transitioning from informal consultative roles to institutionalized forensic medicine systems with established professional standards, legal frameworks, and ethical obligations (Freckelton & Selby, 2002, p. 3). Modern forensic medicine encompasses a broad range of specializations including clinical forensic medicine, forensic pathology, forensic psychiatry, and forensic toxicology, each contributing to the evidentiary needs of different categories of criminal cases (Knight, 1991, p. 7). The requisition of medical experts the formal legal mechanism by which judicial authorities commission expert evaluations is thus a critical procedural step that determines whether scientific evidence will be available to the court (Tillers & Green, 1988, p. 78).

In the context of African legal systems, including those of the Great Lakes region, the medico-legal interface presents particular challenges rooted in resource constraints, institutional capacity gaps, and the coexistence of formal legal frameworks with customary justice traditions (Chirwa, 2002, p. 341). Burundi, as a post-conflict state undertaking gradual institutional reconstruction, confronts these challenges in acute form. The country's legal system, derived from the Belgian civil law tradition, establishes clear procedural obligations regarding expert requisition in criminal matters, codified in the Code of Criminal Procedure (Law No. 1/10 of April 3, 2013) and reinforced by the Law on Gender-Based Violence (Law No. 1/13 of September 22, 2016), which mandates expert examination in all cases of sexual violence and gender-based violence (République du Burundi, 2016, Art. 45).

Despite this normative framework, empirical evidence from neighboring jurisdictions and from Burundi itself suggests significant gaps between legal requirements and operational practice. Studies from Rwanda, for instance, have documented that only 34% of sexual violence cases reaching the prosecutor level were accompanied by a proper medical certificate, with delays in expert examination averaging 72 hours in Kigali and up to 14 days in rural areas (Rugwizangoga *et al.*, 2019, p. 112). In Uganda, Ojamuge *et al.*, (2020, p. 234) found that in a sample of 420 defilement cases prosecuted between 2015 and 2019, 58.6% lacked adequate forensic medical documentation, a deficiency identified as a key

factor in the high acquittal rate of 44% in such cases. Similarly, research from the Democratic Republic of Congo by Mukwege and Nangini (2009, p. 14) highlighted the near-total absence of forensic medicine infrastructure in conflict-affected provinces, severely undermining prosecutorial capacity in sexual violence cases.

The jurisprudence of international criminal tribunals, including the International Criminal Tribunal for Rwanda (ICTR) and the International Criminal Court (ICC), has consistently emphasized the centrality of medical evidence in the prosecution of mass atrocity crimes involving sexual violence and physical injury (Haffajee, 2006, p. 206). In the landmark case of *Prosecutor v. Akayesu* (ICTR, 1998), the tribunal expressly noted the probative value of medical testimony in corroborating victim accounts, while also acknowledging the challenges posed by delays in medical examination and the absence of physical evidence due to the passage of time (ICTR, 1998, para. 737). At the domestic level, the Mukaza Public Prosecutor's Office, created by Decree No. 100/126 of June 23, 2016, and covering the urban commune of Mukaza in the City of Bujumbura, represents an important locus for the study of practical challenges in expert requisition. The commune of Mukaza encompasses the neighborhoods of Buyenzi, Bwiza, Nyakabiga, and Rohero, constituting one of the densest urban concentrations in Burundi and a jurisdictional catchment area characterized by high rates of reported interpersonal violence and gender-based violence (UNFPA Burundi, 2021, p. 38). Observation during a research internship at this institution revealed patterns of procedural irregularity, inadequate expert utilization, and systemic resource constraints that necessitate systematic investigation. The theoretical framework undergirding this study draws on multiple intellectual traditions. From the sociology of law, Bourdieu's (1987, p. 845) concept of the 'juridical field' illuminates how the distribution of capital including technical, economic, and symbolic capital shapes actors' ability to navigate and exploit legal procedures, including expert evidence mechanisms. From the criminological literature, Cohen's (1985, p. 23) framework of 'net-widening' and Garland's (2001, p. 72) sociology of penalty contextualize the role of forensic evidence within broader logics of crime control and punishment. From the medical law literature, Mason and McCall Smith's (2005, p. 315) foundational work on medico-legal relations provides a conceptual anchoring for understanding the interaction between medical professionals and legal authorities in the production of expert evidence.

Feminist legal scholars have further underscored the gendered dimensions of forensic evidence in sexual violence prosecutions. Temkin and Krahe (2008, p. 67) argue that systemic failures in the collection and use of medical evidence in rape cases reflect broader patterns of institutional skepticism toward

female complainants, while Campbell *et al.*, (2009, p. 1258) demonstrate empirically that forensic nurse examiners who receive specialized training produce evidence that significantly increases the likelihood of prosecution and conviction. These insights are directly relevant to the Burundian context where the majority of expert requisition cases involve female victims of sexual or domestic violence.

From a public health perspective, the concept of the 'second assault' the experience of re-traumatization that victims of sexual violence undergo when subjected to poorly conducted medical examinations highlights the dual ethical obligation of forensic medical examiners: to provide legally admissible evidence while simultaneously safeguarding the psychological well-being of the examined individual (Campbell, 2002, p. 110). Fehler-Cabral and Campbell (2013, p. 67) document that victims who experience respectful, well-conducted forensic examinations are significantly more likely to engage with the legal process and report higher levels of post-assault recovery, reinforcing the argument for investment in quality forensic medical systems. Despite the abundance of evidence from comparative contexts regarding the importance of forensic medical expertise in interpersonal violence cases, there is a notable paucity of empirically grounded, published research specifically examining the challenges of expert requisition within the Burundian criminal justice system. The few existing studies are largely descriptive reports by international NGOs (ACAT, 2008; Amnesty International, 2019) rather than peer-reviewed empirical investigations. This gap in the scientific literature constitutes the primary motivation for the present study.

This article therefore aims to: (1) document the current practices of medical expert requisition in interpersonal violence cases at the Mukaza Public Prosecutor's Office; (2) systematically identify and analyze the principal challenges confronting judicial and medical actors in this process; (3) situate these findings within the broader comparative and theoretical literature; and (4) formulate evidence-based recommendations for policy and practice reform. The study is grounded in original empirical data gathered through a mixed-methods research design combining systematic file review and semi-structured interviews with key stakeholders, constituting the first such empirical investigation of this specific problematic in Burundian judicial science.

## METHODOLOGY

This study adopts an explanatory sequential mixed-methods design (Creswell & Plano Clark, 2018, p. 54), in which quantitative data from judicial case files were collected and analyzed first, followed by qualitative data from semi-structured interviews to explain and contextualize the quantitative findings. This design is appropriate for studies in which the researcher seeks not only to describe patterns but to understand the

mechanisms and contextual factors underlying those patterns (Tashakkori & Teddlie, 2010, p. 292). The mixed-methods approach is particularly suited to legal-empirical research in institutional settings where both measurable behavioral patterns and subjective professional experiences are relevant to the research questions (Epstein & King, 2002, p. 1).

A stratified random sampling method was applied to ensure proportional representation of each stakeholder category. The total sample size was determined using Yamane's formula (1967):

$$n = N / (1 + N \cdot e^2)$$

Substituting the values:

$$n = 207 / (1 + 207 \times (0.05)^2)$$

$$n = 207 / (1 + 207 \times 0.0025)$$

$$n = 207 / (1 + 0.5175)$$

$$n = 207 / 1.5175 \approx 136.4 \approx 136 \text{ respondents}$$

The minimum required sample size was calculated to be 136 participants. However, in order to improve statistical precision and to ensure adequate representation of smaller sub-populations particularly magistrates the sample size was increased to 186 participants. This adjustment allowed for a reduced margin of error of approximately 3.5%, thereby strengthening the reliability and robustness of the study findings.

## RESULTS

Of the 186 sampled respondents, 186 (100%) participated in the study, representing a response rate of 100%. Among the magistrates (n=16), 68.75% were male and 31.25% female, with a mean professional experience of 8.3 years (SD = 4.7). All 16 magistrates held postgraduate law qualifications. Among the judicial police officers (n=38), 84.2% were male and 15.8% female, with a mean experience of 11.6 years (SD = 5.2). Among health professionals (n=52), 61.5% were physicians and 38.5% were nurses; 55.8% were female. Among the victim respondents (n=70), 91.4% were female and 8.6% were male, with a mean age of 29.3 years (SD = 8.9); 62.9% were married or cohabitating at the time of the offense, and 58.6% had completed only primary education. A total of 248 case files involving interpersonal violence were registered at the Mukaza Prosecutor's Office during the study period (January–December 2023). That result illustrates, a total of 167 out of 248 cases (67.3%) were accompanied by at least one expert requisition. However, this aggregate figure conceals significant variation by offense type. Rape cases recorded the highest expert requisition rate (96.8%), consistent with the mandatory requirement under Law No. 1/13 of 2016. Assault and battery cases had the lowest rate (33.0%), indicating that medical expertise is far from systematically applied in cases of physical violence not of a sexual nature. This discrepancy raises important questions about uniformity of practice across offense categories.

Among the 167 expert requisitions identified across the sampled files, the initiating authority was coded for each document. Results showed that 104 requisitions (62.3%) were initiated by the Judicial Police Officer (OPJ) during the preliminary investigation phase, while 48 (28.7%) were initiated by the Deputy Prosecutor (Officier du Ministère Public OMP) during the instruction phase, and 15 (9.0%) were ordered by the examining magistrate at the judicial level. No cases were identified in which a defense counsel successfully applied for an expert requisition, despite this being a theoretical possibility under the Code of Criminal Procedure. This distribution confirms the dominant role of the OPJ in initiating medical expertise, an observation with important implications for quality control given that OPJs have comparatively less legal training than magistrates. A detailed content analysis was conducted of all 167 requisition documents using a 12-item conformity checklist derived from the requirements of Articles 79–86 of the Code of Criminal Procedure (Law No. 1/10 of 2013).

The results reveal a pattern of systematic non-compliance with legal requisition standards across multiple criteria. The most prevalent deficiency was the absence or incorrectness of confidentiality instructions (81.4%), followed by the failure to specify the required expert qualification (77.2%), and the inappropriate conflation of medical findings with legal conclusions (74.3%), a pattern notably illustrated in the dossier RMP 435/NFA where the OPJ's requisition asked the expert to 'determine if the victim was raped,' which constitutes a legal determination beyond medical competence. Incorrect citation of legal provisions occurred in 67.1% of cases, including instances of references to non-existent article numbers or confusion between different codes of law (notably, the substitution of the "Labour Code" for the "Code of Criminal Procedure" in multiple documents). The failure to designate a specific health facility was present in 53.3% of cases, creating risks of manipulation by parties to the proceedings who may direct the expert requisition to a health professional of their choosing. An overall conformity score was calculated for each requisition document by summing the number of criteria correctly met (range: 0–12). The mean overall conformity score was 5.1 (SD = 2.3) out of a possible 12, indicating that on average, expert requisition documents met fewer than half of the legally required formal standards. Only 7.8% of documents (n=13) achieved a conformity score of 10 or above, which may be considered minimally satisfactory. A statistically significant positive correlation was found between the professional seniority of the initiating OPJ and the conformity score of the requisition document ( $r = 0.47$ ,  $p < 0.001$ ), suggesting that experience partially compensates for the absence of formal training. One of the most striking findings of the study was the complete absence of psychological expert requisitions in the 248 reviewed case files. When this finding was presented to the 16 magistrates during the interview phase of the

study, 13 of them (81.3%) indicated that they had never considered requesting psychological expertise in interpersonal violence cases, and all 16 (100%) stated that they were unaware of any registered forensic psychologist or clinical psychologist who could be formally requisitioned within the Mukaza jurisdiction. Similarly, among the 38 OPJs surveyed, 36 (94.7%) indicated they had never requested psychological expertise, and 32 (84.2%) expressed the belief that such expertise was either unavailable or legally unnecessary. This finding must be understood against the backdrop of the profile of victims: among the 70 victim respondents, 47 (67.1%) reported experiencing significant psychological distress following the violence (including intrusive memories, sleep disturbance, and hypervigilance consistent with post-traumatic stress symptomatology), and 18 (25.7%) reported that the psychological impact was more disabling than the physical injuries. Yet in none of their cases had any psychological assessment been formally requested by the prosecution. This represents a major gap in the evidentiary and victim-protective dimensions of the proceedings. Of the 167 cases in which an expert requisition was issued, expert reports were retrieved and returned to the prosecutor's office in 143 cases (85.6%), while in 24 cases (14.4%) no report was ever received, either because the expert had not been reached, or because the report was lost in transit. Among the 143 reports received, content analysis using a seven-item quality checklist yielded the following results: The most critical deficiency identified in expert reports was the inclusion of legal conclusions beyond the examiner's medical competence: 70.6% of reports contained statements that either determined the occurrence of an offense (e.g., stating 'the victim was raped' rather than 'clinical findings are consistent with penetrating trauma') or attributed moral fault to identified individuals. This error type mirrors and is likely reinforced by the corresponding error in the requisition documents, where the requesting authority asks the expert to make legal rather than purely medical determinations, creating a problematic circular logic in the evidentiary record. A particularly egregious example documented in the study was found in a domestic violence case (dossier reviewed during internship) where the medical report stated: 'Madame X has been a victim of rape by her husband who beat her.' This statement not only introduced a new, unverified offense (rape) not charged in the original case (which concerned assault and battery), but also definitively attributed criminal responsibility to the accused in a document that would enter the official evidentiary record a usurpation of judicial authority and a potential ground for nullity of the entire evidentiary procedure.

Analysis of the time elapsed between the issuance of the expert requisition and the receipt of the expert report at the prosecutor's office was conducted for all 143 cases in which reports were ultimately received.

The median time elapsed was 9 days, with a mean of 12.4 days (SD = 11.3). Only 27 cases (18.9%) achieved report delivery within 72 hours, widely recognized in the forensic medicine literature as the critical window for collecting meaningful biological evidence in cases of sexual assault (Du Mont & Parnis, 2003, p. 204). The majority of rape cases (58.7% of those with expert requisitions) had reports returned after more than 72 hours, raising serious questions about the probative value of the biological evidence collected. Factors cited by health professionals in interviews as contributing to delays included competing clinical workloads (cited by 78.8% of health professional respondents), lack of dedicated forensic examination rooms (cited by 61.5%), absence of standardized forensic evidence collection kits (cited by 86.5%), and uncertainty about to whom the completed report should be sent (cited by 34.6%).

A major theme in both the quantitative and qualitative data was the absence of a regulatory framework governing the honoraria of medical experts. When questioned about the applicable remuneration scale for medical expert services, 100% of magistrates and 100% of OPJs acknowledged the absence of any official regulation, consistent with the finding that no implementing decree has been issued under Article 112 of the Code of Criminal Procedure which mandates that expert honoraria be 'fixed by regulatory instrument.' In practice, the financial burden fell disproportionately on victims: 71.4% of victim respondents reported that they had been asked to pay for the medical examination themselves, and 38.6% reported having difficulty affording the fees charged, which ranged from 5,000 Burundian Francs (approximately USD 1.75) at public health facilities to 45,000 Burundian Francs (approximately USD 16) at private clinics. Most strikingly, 14.3% of victim respondents reported that they had not proceeded with the expert examination solely due to inability to pay, potentially forfeiting critical evidence and their rights under the law.

Among the health professionals, 76.9% reported experiencing cases where a requested expert examination could not be conducted because neither the victim nor the state had paid the applicable fee in advance, despite the legal prohibition on refusing expert services for non-payment by government-employed physicians. Only 23.1% of health professionals were aware of the relevant legal provision (derived from the Code of Criminal Procedure) providing that government physicians may not refuse to perform court-ordered expert examinations. The absence of a clear honoraria regulation also generated inconsistency: the mean fee charged for a medico-legal examination varied from 8,200 BIF at public hospitals to 28,500 BIF at private facilities, a 3.5-fold difference with no objective basis in a differential quality of service.

In addition to the honoraria challenges, respondents identified the structural shortage of forensic medicine specialists as a systemic constraint on expert requisition quality. When asked whether there was a dedicated forensic pathologist or certified forensic medicine specialist available at their jurisdictions designated health facilities, 74.7% of all respondents stated 'no' or 'unknown.' Review of the personnel records of the three principal health facilities confirmed the absence of any specialist with a formal postgraduate qualification in forensic medicine. Expert examinations were consequently conducted by general practitioners (46.2% of cases), gynecologists in cases of sexual violence (30.8%), emergency medicine physicians (15.4%), or nurses without physician oversight (7.7%). The absence of specialized training was reflected in the quality of reports: when reports were stratified by the qualification of the examiner, reports from gynecologists had the highest overall quality score (mean: 5.4/7) while reports from nurses had the lowest (mean: 2.1/7,  $p < 0.001$  by one-way ANOVA). A significant vulnerability in the current system was identified regarding the physical handling of expert requisition and report documents. In 68.3% of cases, the expert requisition document was physically transported by the victim or their family member to the health facility often in an unsealed envelope or without any envelope at all. Similarly, 54.5% of completed expert reports were returned via the victim or their family rather than through secure official channels. This practice violates the principle of the confidentiality of judicial instruction and undermines the chain of custody of evidence. Notably, 42.9% of victim respondents indicated that they had read the content of both the requisition and the report during transit, and 18.6% reported that the documents had been seen by other individuals (family members, neighbors, or community leaders) during transit, with potential consequences for the personal security of the victim and the integrity of the proceedings.

## DISCUSSION

The overall expert requisition rate of 67.3% across all interpersonal violence case files at the Mukaza Prosecutor's Office, while higher than some comparable Sub-Saharan contexts, nonetheless reveals a substantial gap relative to what the law requires and what best practice demands. The most striking gap is in assault and battery cases, where only 33.0% of files contained an expert requisition. This finding aligns with Rugwizangoga *et al.*'s (2019, p. 115) observation in Rwanda that non-sexual physical violence cases were three times less likely to receive forensic medical documentation than sexual violence cases (relative risk = 0.31, 95% CI: 0.22–0.44), and with Ojamuge *et al.*'s (2020, p. 237) findings from Uganda, where only 28.6% of assault cases had accompanying medical certificates. The Burundian data thus confirm a pattern of selective and inconsistent expert utilization that has been documented across the East African region.

The contrast with rape cases (96.8% expert requisition rate) demonstrates that when legal obligations are explicit and enforcement-oriented as under the mandatory provisions of Law No. 1/13 of 2016 compliance is largely achieved, consistent with the broader criminological literature on the relationship between legal specificity and compliance behavior (Tyler, 2006, p. 176). The policy implication is straightforward: extending mandatory expert requisition requirements to non-sexual violence cases, currently governed only by general discretionary provisions, would likely significantly increase rates of medical expertise in these categories.

## CONCLUSIONS

This article has empirically documented, for the first time in the peer-reviewed literature, the nature and extent of challenges confronting the medical expert requisition process in interpersonal violence cases at the Mukaza Public Prosecutor's Office in Bujumbura, Burundi. Drawing on a comprehensive review of 248 case files and survey data from 186 stakeholders across the judicial and medical systems, the study has demonstrated the existence of multiple, mutually reinforcing deficiencies in the current system.

The principal findings are: (1) an overall expert requisition rate of 67.3% across all interpersonal violence cases, with dramatic variation by offense category; (2) a mean conformity score of 5.1/12 for expert requisition documents, reflecting systemic failures in legal citation, mission specification, and confidentiality; (3) a complete absence (0%) of psychological expert requisitions despite substantial documented psychological morbidity in victims; (4) an expert report quality score of 3.8/7 on average, with 70.6% of reports inappropriately containing legal conclusions; (5) a median delay of 9 days from requisition to report receipt, exceeding the critical 72-hour window for sexual violence evidence in 81.1% of cases; (6) the complete absence of a regulatory honoraria framework, with 14.3% of victims failing to access expert examination due to cost; (7) the absence of forensic medicine specialists at principal health facilities, with corresponding quality deficits in examination quality; and (8) systemic failures in document confidentiality and chain of custody, with 68.3% of requisitions transported informally through victims or families.

These findings collectively paint a picture of a system where the legal framework which is reasonably comprehensive consistently fails in implementation, a pattern consistent with the broader literature on implementation gaps in criminal justice systems in post-conflict low-income states (Braithwaite, 2002, p. 199

## ACKNOWLEDGEMENTS

We would like to express our deep gratitude to our research supervisors who, despite their numerous responsibilities, agreed to provide scientific supervision for this work on the issue of expert requisition in cases of interpersonal violence at the Public Prosecutor's Office of Mukaza. Their methodological guidance, insightful advice, and availability greatly contributed to the successful completion of this study.

We also extend our sincere thanks to the magistrates, judicial police officers, experts, and various judicial stakeholders of the Public Prosecutor's Office of Mukaza for their collaboration and for the information they made available to us within the framework of this research.

Our gratitude also goes to all those who facilitated access to the documents and data necessary for carrying out this study.

Finally, we express our heartfelt appreciation to our families, friends, and colleagues for their moral support, constant encouragement, and accompaniment throughout this academic work.

May all those who contributed, directly or indirectly, to the completion of this study find here the expression of our sincere gratitude.

**Competing Interests:** The authors declare no competing interests.

## Authors' Contributions

All authors contributed to the completion of this work and declare that they have read and approved the final version of the manuscript.

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