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Q&A: ON SEXUAL VIOLENCE IN DETENTION

Through the eyes of a detention doctor: Interview with Raed Aburabi*

Dr Raed Aburabi has been working for the International Committee of the Red Cross (ICRC) for twenty years. He is currently in charge of the health in detention unit at the ICRC's Headquarters in Geneva. As part of his work, he visits countries in which the ICRC operates in order to develop a dialogue with the detaining authorities on improving health services and conditions in places of detention.

In prison, as in the outside world, sexual violence occurs when acts of a sexual nature are imposed by force or coercion. Detention places are, by their very essence, coercive environments where the notion of consent cannot be understood in isolation from the relationship of authority between those with power (be they guards or detainees) and those without. The powerful can, often unchallenged by outside oversight, impose formal and informal rules and regulations. Moreover, the scarcity which is a feature of even the best-run detention environment may lead detainees to engage in acts of a sexual nature in order to access basic goods or services, such as food, water and health care. Sex is further used in detention to pay debts, to gain access to means of communication and to obtain protection. As a result, in detention what may seem to be consensual sex is often far from it, and acts of sexual violence may not be perceived as such.

By virtue of its mandate, the ICRC comes face-to-face with different manifestations of sexual violence in detention and aims to develop a multidisciplinary approach to securing detainees' safety from sexual violence. This includes combating torture and other forms of ill-treatment, but also ensuring acceptable conditions of

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detention and equitable access to food, water, health services, and so on. It also includes supporting better management and oversight, restoration and maintenance of family contacts, and respect for legal safeguards.

In this interview, Dr Raed Aburabi, an ICRC detention doctor, provides a first-hand account of the many manifestations of sexual violence in detention, and reflects on the multiple related needs of detainees and the ways in which an institution such as the ICRC can work to address them.[1]

Dr Aburabi, could you describe some of the manifestations of sexual violence you and your colleagues have encountered in detention places visited by the ICRC? What are some of the causes or risk factors for sexual violence in detention?

First, it is important to mention that it is extremely difficult for victims to speak out about sexual violence, as it affects one's intimacy and sense of dignity. This is true of sexual violence occurring in the outside world, too. But in prisons, sexual activity among prisoners, and between prisoners and staff, is often a disciplinary or even criminal offence. In addition, some forms of sexual activity and sexuality may be considered taboo – for example, same-sex relations and homosexuality – and prisoners often have little opportunity to seek help safely from independent persons. This can make sexual violence a particularly invisible phenomenon. Sexual violence is more common in detention than most people imagine.

Second, while sexual violence is most often referred to in relation to detained women and girls, there is a high prevalence of male victims among detainees. Certainly, in detention places, many women are victims of sexual violence committed by males (including those who demand sex as a condition for access to basic services). But of the ten million or so prisoners around the world, only about 6% are women, so quantitatively, we can say that sexual violence in detention has a great effect also on men and boys.

As for the perpetrators, although staff can certainly commit acts of sexual violence vis-à-vis detainees, sexual violence is also inflicted by detainees on fellow detainees (including children upon other detained children). Sometimes it is possible to observe a hierarchy within the cell or ward. There is a "boss" deciding who can access the shower, or the health clinic for example, and at what price. Then you also have the guards, who may seek to benefit from that bargaining system. In some contexts, the internal stratification is taken to an extreme: the "upper hierarchy" designate fellow inmates as "untouchables", the lowest status in the prison hierarchy. Untouchables struggle to have proper access to food or

1 Editor's note: For a historical background on the ICRC's activities in detention, see Alain Aeschlimann, "Protection of Detainees: ICRC Action Behind Bars", *International Review of the Red Cross*, Vol. 87, No. 857, 2005, pp. 83–122, available at: www.icrc.org/eng/resources/documents/article/review/review-857-p83.htm.

showers; they wear dirty clothes and are completely marginalized – nobody will shake hands with them, eat with them, or have any kind of social interaction. An untouchable carries a high risk of being a victim of sexual violence – of being raped by one or more detainees and even becoming permanently used for sex.

Sexual violence occurs in various degrees around the globe, as a manifestation and vector of the prison system of power and control. It can comprise all manner of humiliating, degrading, cruel and violent acts, including acts inflicted on the sexual organs, and may culminate in rape. There are specific moments when detainees may be at higher risk of sexual violence, for example during initial detention, when the detainee is most disoriented and isolated from the usual support systems. We see many instances of sexual violence in police stations, or during arrest. Perpetrators seem to think that nobody will know what happens during this "transitory" stage, especially when there is no lawyer present, no independent oversight, and/or no one knows where the detainee is and in whose hands. There is also a high prevalence in interrogation centres, where sexual violence is used as a form of torture to obtain information. Other moments of high risk are searches and, for detainees, when sleeping, undressing, washing and using toilets. It is important to understand that not only detainees but also their family members may experience sexual violence in places of detention, both in relation to its use to obtain information and to search procedures required in order to obtain a visit with a detained relative.

You pointed to the fact that sexual violence is to a large extent an invisible phenomenon. How does the ICRC identify detainees who are, or risk becoming, victims of sexual violence?

Although detention doctors have a particular role and opportunity in relation to victims of sexual violence, ICRC visiting teams are not only composed of detention doctors and it is not only they who have the opportunity to conduct private interviews with detainees. ICRC delegates also have that opportunity. The primary source of information on which ICRC visiting teams base their actions on behalf of detainees is usually the accounts given by detainees during these interviews. The information obtained can be supplemented by observation of physical or psychological traces or access to the confidential medical files of individuals, or by more general observations not requiring the intervention of a medical professional. To the extent possible, we make sure that the visiting team is multidisciplinary and gender-balanced, to increase trust and allow the detainees the possibility to talk to someone of the preferred gender. All members of the visiting team know that their role is not to interrogate but to facilitate. It sometimes helps to approach the sensitive issue of sexual violence by talking about risks and personal safety in the prison in general, instead of focusing on individuals. Collecting background information on sexual violence in the context that we visit is also important, including to be able to understand attitudes and allusions to sexual acts, according to the local culture.

In general, you can sometimes pre-identify those particularly at risk of violence. This can be very context-specific, but young detainees, first-time detainees, those with a certain appearance, those with learning or other disabilities, as well as lesbian, gay, bisexual, transgender and intersex persons can be particularly vulnerable. The ICRC detention team must understand relationships of power and control: who are those detainees benefiting from all the privileges, and exercising control over fellow inmates, and who are those at the bottom of the food chain (in the eyes of detainees and staff). When you identify the ones obliged to clean the toilets and the ones being waited on, you can understand who are the "bosses" or those with purchasing power, and conversely, who are the detainees who might be most at risk of sexual violence. This is why understanding the local culture in and outside detention and observing prison life through regular visits are important preliminary steps to successfully addressing sexual violence.

Each ICRC visiting team is aware that it is not only us who observe the detainees' lives; they also observe us. Sexual violence victims will turn to us only if they know they can trust us – and we have to earn this trust. The ability to build a relationship of trust with the detainee, and to create the space for a confidential dialogue, is absolutely key. That requires time, time alone with the detainee. For former detainees, talking about their sexuality inside the prison, and possibly the sexual violence they have suffered from, is a very difficult thing. So imagine what it is to talk about it when you are still inside the prison, when anything you say or do can have a dramatic impact on the way other inmates or staff perceive and treat you. This is a real challenge. As a doctor, I happened to examine patients who had very visible injuries, who were bleeding, but when I asked them what happened to them they would tell me they fell from the stairs, by chance, or they fell on a stick. It is always by accident; they have real difficulty at first in acknowledging that they were victims of an attack of a sexual nature. There are others who show no visible signs, be they physical, psychological or social. So, from my point of view, the best way to approach the topic with a detainee we suspect has been the victim of sexual violence is to let him/her bring up the incident by himself/herself. And you have to give him/her the space to do so. This is not achieved in a single, rushed prison visit – it requires time, and the ability to listen.

Approaching the issue from the medical angle can make things easier, which is why in my opinion it is crucial to have health staff visiting the detention places. I think our role and expertise as doctors explains why detainees often confide more readily in us. You know, our patients do not come to us to talk about the attack itself, but to ask if we can treat the physiological or psychological consequences they suffer from. So they will start to talk about the pain they feel, their symptoms. And little by little, visit after visit, through simple questions the patient will start to share more about what happened. Open-ended questions allow the patient to orient the discussion in the direction he/she feels comfortable with. Sometimes, you can also sense they are expecting you to give them a helping hand or give them a few hints to bring up the issue. Then, some of them

will start to cry; others prefer to put an end to the discussion because it brings back too many painful feelings. As ICRC staff, and as medical professionals, we can give assurances that everything they share with us is confidential and will remain between the two of us if they choose so. These assurances usually allow reopening the dialogue and consideration of how best to address the detainee's needs.

Concretely, how can the ICRC visiting teams, and the detention doctors in particular, assist victims of sexual violence?

Sexual violence is an extremely sensitive topic to address – and especially when committed against men – so the first difficulty is to establish a dialogue with the victim. Once we have established a relationship of trust, we can start addressing the issue. Detainees may face the same physical and mental health consequences as victims of sexual violence *extra muros*. They also suffer social difficulties (exclusion, isolation from other detainees, and a higher risk of being a victim of other forms of abuse), as well as economic ones: being isolated and stigmatized, they may be denied access to goods, including food, or work in the prison. The abuse may also prevent them from being able to economically support themselves and their family once outside the prison – physical or mental harm, as well as lack of self-esteem, can be insurmountable barriers to finding a job. Victims of sexual violence in detention also often face the additional challenge of having to continue living in proximity with the perpetrator(s).

As detention doctors, our aim is thus primarily to inform, reassure and advise the detainee on therapies and services available to them in the prison, if any, and outside, when they are released. We also try, to the extent possible, to address their mental wounds. This implies first sitting and spending time discussing with them, with sympathy, humanity and professionalism – we treat them as any patient, and we do not neglect them. We decide with them what steps we can take to address the harm they have suffered, but also to make the abuse stop.

Indeed, addressing only the consequences cannot be a satisfying end in itself. Always subject to the principle of confidentiality and our patient's consent, the ICRC's visiting team can address the issue with the authorities and/or help the detainee initiate procedures if he/she so wishes. That always happens in accordance with confidentiality rules and with the patient's consent, just as it happens with our patients outside detention facilities. I would ask my patient if he/she wants the prison doctor – or any other prison staff – to know; if my patient refuses, I will not report his/her story. I would not even share the individual story with my ICRC colleagues unless I have the patient's consent. This is the way we build trust – the patient knows we will always respect his/her will, and this spreads quickly amongst other detainees. Sometimes, it takes time. I would visit my patient a second time, and third time, and so on, and over time he/she will realize that I did not share his/her secret with anyone, that I am here to help him/her, and that he/she can trust me and my advice. In this sense, patients may find it easier to confide in an ICRC doctor – someone independent

coming from the outside. This is the preliminary step before reporting the information to anyone outside of the doctor–patient relationship.

If the patient refuses to share the information with the prison authorities, then I would provide him/her with the appropriate treatments and/or advice depending on my medical diagnosis. But if he/she agrees, then I would let the prison doctor know about the file, and we would discuss what can be done (transfer of the detainee, change of cell, etc.). When the measures that the prison doctor can take are insufficient to protect the detainee, as a team we would initiate a dialogue with the prison director – again, subject to the patient's consent. And it is then his/her responsibility to treat the allegation of sexual violence in good faith, to conduct an investigation and to take the necessary measures to put an end to it. This will usually require amendments to a range of procedures and practices and the removal and punishment of perpetrators.

Now, on tackling the issue more generally, as I have already mentioned, the taboo surrounding sexual violence – and sexuality in general – in detention is an enormous obstacle. Yet, it cannot be a reason to ignore it. When I refer the problem of sexual violence to directors of prisons around the world, in the beginning there is often complete denial. After a few days of discussion, tongues are loosened and the prison authority admits that there is sexual violence in the prison, and that they do not know how to address it. Sometimes they do not want to interfere with it. Why? Because they consider that what happens in the prison should stay within the prison walls. There is an incentive for prison staff to turn a blind eye to sexual violence when it constitutes an essential component of the social hierarchy system between inmates – and hence an indirect, albeit violent, means of controlling the detainees. But our role as the ICRC is to bring up the issue, to get the authority to admit that sexual violence is happening behind the prison walls. And then we explain to them that it is their role to address it, and that they actually have an obligation to protect detainees from sexual violence.

Of course, what the ICRC, and those responsible for the care of those detained, should aim for is *preventing* sexual violence from being inflicted in the first place. That can only be done through dialogue aimed at a properly functioning prison system, where safety, dignity and humanity are paramount. But how we get there is a topic for another, long conversation…