The sexual abuse of men in detention in Sri Lanka

To estimate the frequency and consequences of the sexual abuse of men in detention in Sri Lanka, we reviewed records of all Sri-Lankan men who had been referred to the Medical Foundation for the Care of Victims of Torture between January, 1997, and December, 1998. Those on whom medicolegal reports had been written were identified and the necessary information extracted. For the purposes of this paper, sexual abuse comprises assaults to the genitals, non-consensual sexual acts, and objects pushed through the anus. Rape was classed as non-consensual anal penetration with a penis.

Medicolegal reports were written by 17 doctors that supported the allegations of torture in Sri Lanka made by 184 Tamil men who had been referred during this period. During the interview and examination, an assessment was made about the demeanour of the patient, and the reliability of his history. 74 (40%) were aged between 25 and 30 at the time of the analysis, so they would have been several years younger when they were detained and tortured by the Sri-Lankan authorities, principally the army. 25 (13%) were younger than 25 when they were first seen at the Medical Foundation, 71 (38%) were aged 30–40 years, and 14 (6%) were older than 40. There was no significant difference in the proportion of each age-group who said they had been sexually abused.

Of the 184 men, 38 (21%) said they had been sexually abused during their detention. Three (7%) of the 38 said they had been given electric shocks to their genitals, 26 (68%) had been assaulted on their genitals, and four (9%) had sticks pushed through the anus, usually with chillies rubbed on the stick first. One said he had been forced to masturbate a soldier manually, three had been made to masturbate soldiers orally, and one had been forced with his friends to rape each other in front of soldiers for their "entertainment".

Of the men who said they had been sexually abused, 11 reported being raped as part of that sexual abuse; this represents 5% of the total number of men on whom reports were written. The men who had been raped were much younger, on average, than the men who said they had not been raped. This suggests that the soldiers choose the younger and more vulnerable men to rape.

Of the 38 men who had been sexually abused, only four (10%) had scarring of the genitals, and none of them were found to have significant scarring around the anus. Since there are very rarely any physical signs caused by acute sexual assault of men,[1] it is not surprising that there were so few men with physical signs of their sexual abuse. The injuries were: thickening and tenderness of final 1–2 cm on urethra of a man who described a soldier pushing an object inside his penis; a scar on the base of shaft of penis of a man who said that soldiers had repeatedly slapped a heavy desk drawer shut on it; an irregularly defined defect in the foreskin of a man who said that soldiers had tied some string around his penis and pulled, tearing off a piece of his foreskin; and a cigarette burn on the scrotum of a man who said that soldiers had stubbed cigarettes out on his genitals.

Of the 184 men, 45 (24%) described a range of psychological symptoms that included difficulty getting to sleep, waking with nightmares, jumpiness and irritability, behaviour to avoid being reminded of the detention, and depression. These are all symptoms of post-traumatic stress disorder (PTSD). 29 (15%) men had many of the symptoms of PTSD, but not enough to be consistent with the full diagnosis. Of these, only two (5%) gave a history of sexual abuse. 43 (23%) of the men described disturbance of their sleep as their only psychological symptom. Of these, five (13%) had a history of sexual abuse. Two (1%) men were anxious, but had no other psychological symptoms. 65 (35%) of the men said that they did not have any psychological symptoms. Of these, ten (26%) gave a history of sexual abuse.

Sexual abuse in detention starts with forced nudity, which many of the Sri Lankan detainees described. This is usually associated with verbal sexual threats and mocking, which adds to the humiliation and degradation of being tortured. In 37 (20%) of the men in this study, this psychological sexual abuse was followed by physical abuse, and 5% were raped by or at the instigation of their captors.

There is some awareness of sexual assault in detention in Sri Lanka in the general population, and for those to whom this happened, it was a form of physical assault used in the course of interrogation. Rape of men in detention has never been discussed in the press, so those who had been raped would not have been prepared. Most said they had been taken out individually by the soldiers on guard and raped. Most were not able to describe the detail of the rape, because they did not have the language to explain what happened. They felt that they had been picked because they were young. Most were telling of the experience for the first time in their interview at the Medical Foundation. Most of these men had not told the authorities, particularly because they were too ashamed. Shame is a very real deterrent to seeking all forms of help for both male and female victims of rape.

Other difficulties for male rape victims are caused by common myths about male rape, for example, the belief

Equity, post-conflict, and human rights

A meeting in Ottawa, Canada earlier this year, brought together researchers, non-governmental organisations, and policy makers concerned with the challenges facing countries emerging from major periods of conflict. Those represented included Rwanda, Bosnia, Kosovo, East Timor, Mozambique, Angola, and Somaliland.

Among the key issues debated was how equity should be addressed in "post-conflict" settings. Inequitable distribution of development resources, services, and economic and political power, are potent contributors to intranational conflict. Following conflicts, opportunities to rethink and redesign health systems may be present. Reaching agreement about the values underlying the system, including the extent to which equity will be promoted, is crucial.

Failure to recognise the need to incorporate such values may reinforce differences between communities and their access to resources and services, so investment in identifying good practice assessment tools and intervention strategies is required.

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